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ARTICLE

THREE MODELS OF HEALTH INSURANCE: THE CONCEPTUAL PLURALISM OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

ALLISON K. HOFFMAN[†]

What risks should health insurance mitigate? American health scholars, politicians, and the public at large answer this question ambivalently. This Article defines three dominant conceptions of health insurance that weave throughout popular and academic discourse and that echoed in the 2010 health reform debates. The first conception is that health insurance should primarily serve to mitigate harms to health. This “Health Promotion” theory relies on using health insurance to pay for medical care that most cost-effectively preserves and improves health. Alternately, health insurance might primarily mitigate risks to wealth from high medical care costs. This “Financial Security” theory demands that health insurance limit financial insecurity from these costs. Finally, the “Brute Luck” theory, highly sensitive to the possibility of adverse-incentive effects arising from moral hazard, demands that health insurance protect primarily against unavoidable or “chance” health risks that do not arise from individual behavior. This last theory thus seeks to preserve incentives for insureds to prevent risk themselves, while insurance neutralizes harms from random poor health. Each theory implies distinct principles to guide premium pricing and allocation of premium dollars toward medical care.

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The new health reform law, the Patient Protection and Affordable Care Act of 2010 (PPACA), manifests this “conceptual pluralism.” It evokes all three of these notions of the types of risks Americans should share—now more collectively post-reform—through insurance. While the goals of these three theories dovetail at times (e.g., promoting health will in some cases also reduce medical care costs), at other times they are at odds. Conceptual pluralism thus complicates implementation of PPACA as regulators must manage tensions and make tradeoffs among these goals.

The framework offered in this Article is important for two reasons. First, creating a roadmap to understand the different conceptions of insurance, and the values that inform them, brings awareness to the root cause of tensions that will arise as PPACA is implemented. Second, this framework elucidates the different ends that health insurance could serve and thus enables clearer future reflection and debate on what ends it should serve and to what degree.

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INTRODUCTION

Health insurance has become a regular topic of dinner-table and watercooler conversations with the recent passage of a national health insurance reform law—the Patient Protection and Affordable Care Act¹ and the Health Care and Education Reconciliation Act of 2010² (collectively referred to herein as “PPACA”). But when Americans talk about health insurance, they are not all talking about the same thing.

Americans simultaneously hold several conceptions about what health insurance is (and often, impliedly, should be). Some think health insurance should pay for care to maintain our health. Others see it as a tool to protect us against medical bankruptcy or other types of financial insecurity that arise from expensive and rising medical care costs. Finally, others think it should indemnify costs we cannot reasonably prevent on our own—unavoidable risks. Some think insurance should serve two or three of these goals simultaneously. Yet, each of these three conceptions implies a distinct starting point for determining what health insurance should accomplish and for whom.

This Article draws on scholarly, political, and popular discourse on insurance to define what I contend are the three dominant American conceptions of health insurance.³ The ideas and arguments underlying these three distinct (yet overlapping) models of health insurance have for years colored discussions of health insurance, most recently woven throughout health reform debates, but this Article is the first to untangle and explore them systematically. By making explicit this conceptual pluralism, this Article elucidates normative underpinnings of health insurance debates, as well as the root causes of tensions that will arise as PPACA is implemented.

PPACA has shone a light on medically related risks and how we manage them. The law amplifies the importance of collective risk management through health insurance as described in Part I. This Part reviews how PPACA increases the extent to which health insurance redistributes risk. For example, the law requires Americans to

¹ Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

² Pub. L. No. 111-152, 124 Stat. 1029 (to be codified in scattered sections of 20, 26, and 42 U.S.C.).

Although the main text of this Article refers to PPACA and HCERA collectively as “PPACA,” the footnotes cite the two Acts separately.

³ There are undoubtedly other conceptions as well, but I see these three as the most strongly and frequently evoked.

carry health insurance,⁴ increasing the population who will engage in collective risk management. It also requires private health insurance to be more “solidaristic,” characterized by broader sharing of risks among rich and poor, and among healthy and sick (what I have previously described as “health redistribution”).⁵ However, it does not privilege a singular conception of the risks Americans must share, now more collectively, through mandatory health insurance. Rather, the law mirrors normative values underlying all three dominant American conceptions of health insurance.

In Part II, I examine the three theories in depth, including arguments in support of each theory and different ways that the values behind these theories might be translated into practice. The first theory is that health insurance should promote health.⁷ Insurance dollars

⁴ PPACA § 1501, 26 U.S.C.A. § 5000A (West Supp. 1A 2010).

⁵ Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 AM. J.L. & MED. 7, 11 (2010). This article contends that an individual mandate in conjunction with insurance-market reforms that require greater risk pooling can promote greater solidarity through “health redistribution,” or a pooling of risks among healthy and sick. *Id.*

⁶ For a discussion of solidarity and PPACA, see Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577 (2011). “The Affordable Care Act embodies a social contract of health care solidarity through private ownership, markets, choice, and individual responsibility.” *Id.* at 1579.

⁷ This idea has been advanced and described by scholars in several ways. First, some advocate the importance of medical care and the role of insurance in ensuring access to care. See, e.g., Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS U. L.J. 7, 9-10 (1994) (arguing that “promotion of the health of the population is the most important objective of health care reform” and that access to medical care is a critical—though not the sole—component of promoting health); Ronald R. Loepke, *Making the Case for Population Health Management: The Business Value of Better Health* (“Health plans’ specific responsibilities include improving the health of the members . . .”), in POPULATION HEALTH 121, 130 (David B. Nash et al. eds., 2011); Wendy K. Mariner, *Health Reform: What’s Insurance Got to Do with It? Recognizing Health Insurance as a Separate Species of Insurance*, 36 AM. J.L. & MED. 436, 450 (2010) (“A more transparent approach to reform would make explicit that health plans constitute a valuable, separate species of insurance designed primarily to finance socially beneficial health services by spreading the cost of care.”); John A. Nyman, *The Value of Health Insurance: The Access Motive*, 18 J. HEALTH ECON. 141, 142 (1999) (“Additional benefits are derived from insurance’s ability to make available medical care that would not otherwise be affordable.”). Many make a related argument that the lack of insurance or insufficient insurance leads to poorer health. See, e.g., COMM. ON THE CONSEQUENCES OF UNINSURANCE, INST. OF MED. OF THE NAT’L ACADS., HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA 4 (2003) (estimating that “the aggregate, annualized cost of the diminished health and shorter life spans of Americans who lack health insurance is between \$65 and \$130 billion annually for each year of health insurance foregone” (emphasis omitted)); Jonathan Gruber, *Covering the Uninsured in the United States*, J. ECON. LITERATURE 571, 582-83 (2008) (citing studies demonstrating the adverse impact of the lack of insurance on

are most valuable, according to this notion, if spent on interventions that cost-effectively maintain or improve health. Core characteristics of insurance from this perspective include prioritized spending on high-value care, defined as care that produces the most health benefit per dollar spent, and less spending on what are generally considered lower-value interventions, such as high-end diagnostics and, often, end-of-life care.⁸ This “Health Promotion” paradigm of health insurance is reflected in the work of scholars such as Larry Gostin who think about health insurance in connection with broader public health goals (e.g., education, nutrition, and housing), or those, such as Michael Chernew, Donald Berwick, and Michael Porter, who think about improving the value of health care through organizational design.⁹ Key PPACA policies could be understood to reflect this conception of health insurance. For example, the law prohibits insurers from charging copayments for preventive care, under the presumption that

health); Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured*, MED. CARE RES. & REV., 3S, 60S (2003) (“[T]here is a substantial body of research supporting the hypothes[is] that having health insurance improves health”); Shana Alex Lavarreda et al., *Underinsurance in the United States: An Interaction of Costs to Consumers, Benefit Design, and Access to Care*, 32 ANN. REV. PUB. HEALTH 471, 480 (2011) (arguing that “along with the accepted frameworks for defining underinsurance in economic terms or as a function of lacking needed benefits, the effect of underinsurance on access to care should be considered as well”); Diane Rowland & Adele Shartzter, *America’s Uninsured: The Statistics and Back Story*, 36 J.L. MED. & ETHICS 618, 618 (2008) (“The large and growing number of uninsured people is of concern because health coverage makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately how healthy people are.”). Finally, the idea that health insurance should be designed with health promotion as the primary goal is often implied by arguments for value-oriented health care design. See, e.g., MICHAEL E. PORTER & ELIZABETH OLMSTED TEISBERG, *REDEFINING HEALTH CARE* 229 (2006) (“Health plans must become health organizations, not just insurance organizations.”); Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759, 760 (2008) (arguing that “the United States will not achieve high-value health care unless improvement initiatives pursue a broader system of linked goals,” including “improving the health of populations”); Michael E. Chernew et al., *Value-Based Insurance Design*, HEALTH AFF., Jan. 30, 2007, at W195, W202, <http://content.healthaffairs.org/content/26/2/w195.full.pdf> (arguing that value-based insurance design could “align[] . . . incentives based on overall value of clinical services, not just cost” and could therefore help “move toward a high-value health care system for all”).

⁸ See e.g., Robert H. Blank, *Regulatory Rationing: A Solution to Health Care Resource Allocation*, 140 U. PA. L. REV. 1573, 1579 (1992) (“We have developed an unrealistic dependence on technology to fix our health problems at the expense of preventive health care approaches.”); Katherine Swartz, *Uninsured in America: New Realities, New Risks* (“Slowing growth in health care spending ultimately will not be possible unless the basic benefits package excludes treatments that are enormously expensive and not cost-effective.”), in *HEALTH AT RISK: AMERICA’S AILING HEALTH SYSTEM—AND HOW TO HEAL IT* 32, 56 (Jacob S. Hacker ed., 2008).

⁹ See *supra* note 7.

such care is relatively high value, so that every American can seek out basic preventive services without paying a dollar of her own money, regardless of individual ability to pay.¹⁰ In so doing, it creates a strong incentive for every American to consume preventive care, with the goal that such care will improve health and quality of life, even if it does not save money in the long run.¹¹ This theory also undergirds investment in comparative effectiveness research, which aims to identify the relative value of health care interventions.¹²

The second theory is that health insurance should first and foremost mitigate financial vulnerability arising from health care spending. Professors Jerry Mashaw and Michael Graetz, for example, have embraced this “Financial Security” notion of health insurance in their book *True Security*.¹³ This theory is also echoed in recent literature on underinsurance, health expenditures, and medical bankruptcy by Jacob Hacker, Melissa Jacoby, David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, among others, who criticize insurance for not providing sufficient financial protection.¹⁴ This approach prioritizes indemnifying medical expenses that significantly threaten financial stability.¹⁵ Key policies of PPACA are designed with

¹⁰ PPACA sec. 1001, § 2713, 42 U.S.C.A. § 300gg-13 (West Supp. 1A 2010).

¹¹ One can question whether preventive care will actually achieve such a goal. Whether this policy is well crafted or not is distinct from the point that it is included in PPACA based on a *belief* that it can improve health.

¹² PPACA, Pub. L. No. 111-148, §§ 6301–6302, 124 Stat. 119, 727-47 (2010) (to be codified in scattered sections of 26 and 42 U.S.C.).

¹³ See MICHAEL J. GRAETZ & JERRY L. MASHAW, *TRUE SECURITY* 146 (1999) (“[I]t is the job of social insurance to protect family income streams . . .”).

¹⁴ See JACOB S. HACKER, *THE GREAT RISK SHIFT* 138 (2006) (“Every thirty seconds, someone files a bankruptcy claim that’s due in part to medical costs . . .”); Jacob S. Hacker, *Privatizing Risk Without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States*, 98 AM. POL. SCI. REV. 243 (2004) (arguing that the convergence of stagnant policies and changing social realities has left Americans more financially vulnerable); David U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF., Feb. 2, 2005, at W5-63, W5-72, <http://content.healthaffairs.org/content/early/2005/02/02/hlthaff.w5.63.full.pdf+html> [hereinafter Himmelstein et al., *Illness and Injury*] (noting that “middle-class Americans . . . face impoverishment following a serious illness”); David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 743 (2009) [hereinafter Himmelstein et al., *Medical Bankruptcy*] (finding that medical bills contribute to many bankruptcies); Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH POL’Y L. & ETHICS 239, 240, 286 (2010) (claiming that the court-record method, which involves looking at the court documents submitted by bankruptcy filers, “is an unreliable measure of the financial burden of illness or injury faced by bankruptcy filers” and underrepresents the actual hardship).

¹⁵ Cf. GRAETZ & MASHAW, *supra* note 13, at 171 (discussing how medical expenses should be limited to protect patients’ standard of living).

such a goal in mind. For example, the law caps possible out-of-pocket cost-sharing obligations for all policies.¹⁶ It also provides subsidies that prevent insureds from paying more than a certain percentage of their income toward premiums and cost-sharing obligations.¹⁷

The third and final theory is that health insurance—in the classic image of liability insurance¹⁸—should protect primarily against those risks an insured should not reasonably avoid on her own, including risks whose avoidance would be unduly expensive or burdensome. This “Brute Luck” approach to health insurance is justified in two different ways.¹⁹ First, some “luck egalitarians” demand heightened attention to neutralizing suffering from unavoidable harms.²⁰ Others, including Kenneth Abraham and Mark Pauly, argue that such an approach will promote more efficient risk avoidance or limit moral hazard.²¹ This particularly American notion requires those who assume a higher risk of poor health to pay more for protection against the harms and costs that may ensue. In contrast, insureds who prevent such risks through healthy lifestyles (e.g., eschewing smoking and fast

¹⁶ PPACA § 1302(c), 42 U.S.C.A. § 18022(c) (West Supp. 1B 2010).

¹⁷ PPACA § 1401, 26 U.S.C.A. § 36B (West Supp. 1A 2010) (providing for “premium tax credits”); *id.* § 1402, 42 U.S.C.A. § 18071 (West Supp. 1B 2010) (providing for “cost-sharing reductions”).

¹⁸ According to Eric Mills Holmes,

[T]he earliest definition of insurance drew upon the fortuity principle and created a test to define insurance based on control (not fortuitous) or the lack of control (fortuitous) over the insured loss by the insured or insurer. This notion of control gave rise to the use of a “substantial control” test by anyone attempting to determine if a particular business was the “business of insurance” or a particular transaction constitutes “insurance.”

16 ERIC MILLS HOLMES, HOLMES’ APPLEMAN ON INSURANCE § 116.2 (2d ed. 2000).

¹⁹ As Part II will discuss, there are two main lines of argument for this theory. First, insurance can reduce incentives for individuals to care for themselves or to prevent health harms, a particular type of moral hazard; thus, insurance should cover only random risks to maintain incentives for risk avoidance. See, e.g., KENNETH ABRAHAM, DISTRIBUTING RISK 35-36 (1986) (discussing how moral hazard concerns have influenced insurance policy and pricing practices over time); Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531, 537 (1968) (“[E]ven if all individuals are risk-aversers, some uncertain medical care expenses will not and should not be insured in an optimal situation.”). But cf. TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK 128 (2007) (discussing an experiment that “found absolutely no evidence of ex ante moral hazard—that people engaged in more risky behaviors because they faced lower cost sharing” (citing JOSEPH P. NEWHOUSE & THE INSURANCE EXPERIMENT GROUP, FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 200-01, 208 (1993))). Second, some advance a luck-egalitarian argument for a theory of distributive justice that requires neutralizing unavoidable harms. See *infra* notes 228-32.

²⁰ For a discussion of luck egalitarianism, see *infra* Section II.C.

²¹ For examples of Abraham’s and Pauly’s arguments, see *supra* note 19.

food) and cautious living (e.g., limited skydiving or helicopter-skiing adventures) pay less. In the same way that home insurance will not compensate for damages caused by a fire that the homeowner intentionally sets or the way that life insurance policies might exclude suicide within a period after the policy is initiated,²² health insurance might not reimburse harms that are self-inflicted, negligently induced, or avoidable. The primary role of insurance becomes the mitigation of chance harms, or those harms resulting in whole or in part from so-called brute bad luck or lottery with regard to health. Of course, distinguishing choice from chance is complex and controversial, as explored below in Section II.C.

While parts of PPACA mute the Brute Luck conception of insurance, several key policies could be understood to reflect it. PPACA prohibits insurers from discriminating against applicants on the basis of most health conditions but allows them to discriminate in cases in which insureds have arguably either assumed or, inversely, prevented risks. For example, insurers can charge smokers more for health insurance.²³ They can also provide wellness-program discounts to people who, presumably, are responsibly preventing health risks through such programs.²⁴

I simplify these three theories of health insurance for purposes of developing a coherent framework, but, as I describe each theory, I simultaneously acknowledge and tease out its internal tensions. For example, a Health Promotion model requires identifying what types of harms to health insurance should protect against and for whom. But promoting health means different things to different people, depending on which particular health outcome they most value. Likewise, implementing a Financial Security model requires defining what constitutes financial security; supporters of this approach define security—and thus the ideal boundaries of health insurance coverage—differently. Adherents to a Brute Luck approach likely disagree as to what are reasonably avoidable risks versus unavoidable chance risks. In Part II, I attempt to show the main thread of logic that defines the

²² HOLMES, *supra* note 18, § 116.2 (describing the role of the fortuity principle in insurance).

²³ See PPACA sec. 1201, § 2701(a)(1)(A)(iv), 42 U.S.C.A. § 300gg(a)(1)(A)(iv) (West Supp. 1A 2010) (allowing premiums to vary by no more than 1.5 to 1 based on “tobacco use”).

²⁴ *Id.* sec. 1201, § 2705(j), 42 U.S.C.A. § 300gg-4(j). Such programs can simultaneously promote health if effective.

models, while recognizing that different strands of interpretation weave out in different directions from the main thread.

This framework aims to shed light on the interactions and, at times, conflicts between these different conceptions of health insurance. These three conceptions of health insurance are overlapping and certainly not mutually exclusive. These conceptions sometimes coexist harmoniously, when policies satisfy goals in line with multiple visions. At other times, however, they come into conflict. Each theory implies a different starting point for thinking about insurance and distinctive criteria for prioritizing which risks are most important to redistribute through insurance (and, perhaps, which risks should fall outside the bounds of collectivization). In the extreme, imagine if health insurance policies covered only one of the following items:

1. Recommended colon cancer screenings to promote early detection for a man in a middle-class family who lives a healthy, low-risk lifestyle;
2. Medical care for an obese man with diabetes who otherwise faces potential bankruptcy because of his high medical care costs related to his obesity;
3. Coverage of the costs of breast reconstruction surgery for a forty-year-old corporate attorney with breast cancer, who has a type of cancer that suggests a genetic predisposition.

Colon cancer screenings are an element of long-term health promotion for the healthy man, although low-cost enough that he could likely afford the screenings even if not covered by insurance. Insurance coverage for the diabetes care could save the obese man from financial ruin resulting from the high expense of treating a serious chronic condition, despite the fact that some might argue he assumed the risk of such expense by becoming and remaining obese and thus is less deserving of rescue now. Finally, the lawyer could afford breast reconstruction without insurance (though at great personal expense), but because she suffers from cancer due in part, or whole, to her genetics, insurance could neutralize her bad genetic luck. All of these medical interventions are valuable in different ways, and, in an ideal world, some might want health insurance to pay for all three. But if tradeoffs were necessary, some would prioritize insurance coverage for the first, others the second, and yet others the third, depending in part on their view of the most important function of health insurance.

To be clear, this Article does not intend to resolve tensions among these different normative approaches to health insurance.²⁵ Nor does

²⁵ Philosophers and scholars have long debated the best way to allocate and fund medical care, a question that is complex, heated, and impossible to resolve in the

it intend to suggest that this conceptual pluralism—and its reflection in PPACA—is surprising or undesirable. Legislators and policy-makers, like any other Americans, had aspects of these three conceptions in mind as they crafted PPACA.²⁶ Furthermore, pluralism is not uncommon in legislation and is especially unsurprising in the case of PPACA, given an ambivalent electorate, the divisive political process that led to passage of the law, and significant compromise over many months.²⁷ If the legislation had failed to appeal to a majority coalition—a majority that does not share any single conception of what health insurance should do—it would not have passed. In other words, if, as I contend, Americans expect different ends from health insurance, then health insurance reform was destined to reflect pluralistic visions of insurance in order to prevail.

This Article intends to make conceptual pluralism explicit so that it is clear when policies are informed by a particular set of values and when tradeoffs are made among these three visions of insurance. Even if pluralism was necessary for enactment, PPACA's pluralistic nature will complicate its implementation. When translated into policy, the three principles will at times conflict, creating discordance among PPACA policies.

With no single normative roadmap, regulators must wrestle with these three conceptions of insurance when defining PPACA policies in regulations (whether they do so consciously or not). PPACA leaves many of the most important policy-design elements to regulatory specification, and the regulatory process is already proving to be a chal-

bounds of this Article. For a summary review of these debates, see NORMAN DANIELS, *JUST HEALTH: MEETING HEALTH NEEDS FAIRLY* 11-28 (2008). See also Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1496 (1994) ("Once we abandon a commitment to fund every health benefit possibly achievable, we face difficult choices about which health improvements to fund out of a limited set of resources."); Govind Persad et al., *Principles for Allocation of Scarce Medical Interventions*, 373 LANCET 423, 424 tbl.1 (2009) (listing eight principles of allocating health care and the advantages and disadvantages associated with each).

²⁶ See quotations introducing Sections A, B, and C of Part II.

²⁷ See LAWRENCE R. JACOBS & THEDA SKOCPOL, *HEALTH CARE REFORM AND AMERICAN POLITICS* 11-16 (2010) (providing a timeline of the major events from March 2007 to March 2010 resulting in the passage of the health care reform bill); see also THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 43-61 (2d ed. 2000) (describing the machinations and compromises leading to the passage of the Medicare bill); DEBORAH STONE, *POLICY PARADOX* (rev. ed. 2002) (illustrating the contradictions throughout American politics and policymaking); Rudolf Klein & Theodore R. Marmor, *Reflections on Policy Analysis: Putting It Together Again* (describing public policy as an elusive creature, "resolving (or at least attenuating) conflicts about resources, rights, and morals"), in *THE OXFORD HANDBOOK OF PUBLIC POLICY* 892, 892 (Michael Moran et al. eds., 2006).

lenge.²⁸ The implementation of key insurance regulations, such as the medical loss ratio,²⁹ “essential health benefits,”³⁰ and processes for oversight of insurance premium increases, will differ depending upon which conception of health insurance dominates.³¹

By understanding these three dominant American theories of health insurance and the tensions they create among various provisions of PPACA, regulators can more thoughtfully address these tensions as they arise. Furthermore, Americans can better understand the tradeoffs regulators and policymakers must make among these conceptions of insurance in the creation and implementation of health insurance policies.

I. HEALTH INSURANCE, THE DISTRIBUTION OF RISK, AND ENHANCED SOLIDARITY UNDER PPACA

Before describing these three different conceptions of health insurance, it is important to consider briefly how health insurance—particularly private insurance, the focus of this Article—manages and redistributes risks, as well as how it will increasingly do so following PPACA’s reforms. As PPACA amplifies redistribution, it enhances the importance of what risks are distributed and among whom.

Even in its least distributive forms, insurance facilitates two different types of distribution of risks: intertemporal and interpersonal.³² Intertemporal distribution is the spreading of risks faced by one individual over a lifetime (i.e., consumption smoothing). In this regard, insurance can be seen as a mechanism either to save for future losses through premiums paid today or to borrow for today’s expenses

²⁸ See Eric Lichtblau & Robert Pear, *Rule Makers Emerge from the Shadows*, N.Y. TIMES, Dec. 9, 2010, at A28 (describing the rulemaking challenges that recent “mega-bills” like PPACA pose).

²⁹ See PPACA secs. 1001, 10101, § 2718(b)(1)(A), 42 U.S.C.A. § 300gg-18(b)(1)(A) (requiring the Secretary of Health and Human Services (HHS) to determine through regulations how to implement the medical loss ratio requirement that insurers spend 80% to 85% of premiums on medical care).

³⁰ See PPACA § 1302, 42 U.S.C.A. § 18022 (West Supp. 1B 2010) (requiring the Secretary of HHS to define through regulations which “essential health benefits” nongrandfathered health plans in the individual and small-group markets must cover).

³¹ See *infra* Part III.

³² While some believe that an efficient insurance market could eliminate interpersonal redistribution by charging each individual a perfectly actuarially rated premium (defined as the exact amount the individual is likely to consume in health care costs over the coverage period), the reality is that even in the most “efficient” of insurance markets, there is both intertemporal and interpersonal redistribution. ABRAHAM, *supra* note 19, at 77.

by paying premiums for years to come. Insurance also spreads risks interpersonally across individuals in a risk class—in other words, a pool designed for sharing risks (i.e., risk pooling). Risks are pooled more broadly both when the boundaries of a risk pool are larger and when insurance coverage and prices are more similar among the insured in a pool (e.g., when prices and coverage are not tailored based on an individual's risk).

The degree to which an insured shares risk with others in her risk pool has historically differed based on the source of her insurance.³³ American health insurance is bifurcated into public insurance (e.g., Medicare and Medicaid) and private insurance. Private health insurance was the source of insurance for about 195 million Americans in 2009 prior to PPACA,³⁴ and it will be the source for even more following PPACA's reform.³⁵ Private health insurance is offered in three markets: large group (over 50 or 100 employees depending on the state), small group, and individual.³⁶ While all three markets facilitate both intertemporal and interpersonal redistribution of risks, the large-group market has historically distributed risks more completely than the small-group and, especially, the individual market.³⁷ Most private health insurance is large-group, employer-sponsored insurance (ESI), which employers may, but are not required to, offer to employees or retirees.³⁸ Employers gather heterogeneous groups of employees together as a risk pool, and, because of the nondiscrimination requirements of the Health Insurance Portability and Accountability Act of

³³ See Hoffman, *supra* note 5, at 50-52 (describing how greater fragmentation of markets leads to less sharing of risks).

³⁴ CARMEN DENAVAS-WALT ET AL., U.S. DEP'T OF COMMERCE, CURRENT POPULATION REPORTS, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 71 tbl.C-1 (2010). In addition, in 2009, just over ninety-three million Americans had public health insurance, in the form of Medicare, Medicaid, or military health care. *Id.* For a critical description of this federal "patchwork of health-care programs," see TOM DASCHLE WITH SCOTT S. GREENBERGER & JEANNE M. LAMBREW, CRITICAL: WHAT WE CAN DO ABOUT THE HEALTH CARE CRISIS 29-31 (2008).

³⁵ See Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives 9-10 (Mar. 20, 2010), available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf> (projecting the extent to which PPACA and HCERA together would increase private health insurance coverage).

³⁶ See Mark A. Hall, *The Geography of Health Insurance Regulation: A Guide to Identifying, Exploiting, and Policing Market Boundaries*, HEALTH AFF., Mar.-Apr. 2000, at 173, 173-75 (illustrating how the lines between these markets are fluid due to "border-crossing" structures and techniques).

³⁷ See Hoffman, *supra* note 5, at 50-51.

³⁸ See DENAVAS-WALT ET AL., *supra* note 34, at 71 tbl.C-1 (showing that nearly 170 million of the nearly 195 million privately insured individuals have ESI).

1996 (HIPAA), such employers must offer insurance on the same terms to all employees, thus spreading risks equally among all members of a risk pool.³⁹ For group insurance, HIPAA also limited exclusion of coverage for preexisting conditions⁴⁰ and required insurers to issue coverage to any applicant (a policy known as “guaranteed issue”).⁴¹ This requirement means that every employee can get coverage for any condition included under an employer’s policy.

Prior to PPACA, the individual market, where people who generally do not have access to ESI buy insurance directly from an insurer, was less effective at risk distribution. Insurers in most states’ individual markets could issue, decline, or differentially price insurance based on an individual’s prior health experience or expected risk—a practice known as underwriting or “risk rating.”⁴² This practice limited both who could gain entry to risk pools and the degree of distribution of risks for those who did.⁴³ Commercial insurers in the individual market aim to charge premiums based on an individual’s expected losses plus a share of administrative costs—a process which, if done precisely, would limit interpersonal risk distribution because each individual would pay her expected share of the pool’s total costs.⁴⁴ Stu-

³⁹ See 29 U.S.C. § 1182 (2006 & Supp. III 2009) (“[p]rohibiting discrimination against individual participants and beneficiaries based on health status”). While the terms might be facially neutral, however, employers could still carve out whole categories of treatment in a way that might have a disparate impact on employees. See, e.g., *McGann v. H&H Music Co.*, 946 F.2d 401, 403, 408 (5th Cir. 1991) (holding that an employer who reduced the medical benefits for employees with AIDS did not discriminate illegally).

⁴⁰ 29 U.S.C.A. § 1181 (West Supp. 1A 2010).

⁴¹ 42 U.S.C. § 300gg-11 (2006 & Supp. III 2009) (current version at 42 U.S.C.A. § 300gg-1 note (West Supp. 1A 2010)).

⁴² For a description of risk rating, see generally Donald W. Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 JAMA 2503 (1992). Some states limit experience rating. See discussion *infra* note 44.

⁴³ See Hoffman, *supra* note 5, at 53-55.

⁴⁴ Both actuarial and regulatory limitations prevent perfect precision. See ABRAHAM, *supra* note 19, at 77 (“Insureds are unlikely to suffer the exact amount of their expected losses over the course of their insuring lives.”). Insurers do not define risk classes as narrowly as actuarially possible. At some point the administrative costs of defining classes narrowly enough to cabin redistribution and attract low-risk enrollees exceeds the benefit from enrolling additional subscribers. Furthermore, even if profitable, it is presently impossible to gauge individual risk perfectly. Expected risk is only really defined once people are grouped with others so that group probabilities can be calculated, which by definition means the costs of losses will be spread among the risk group, however defined. *Id.* at 79. Finally, both federal and state regulations have limited insurers’ freedom to decline applicants or charge them differentially on the basis of health or other characteristics. For example, according to Kaiser Family Foundation research, about a third of the states have community rating or rate bands that limit the variance in

dies suggest that as many as three in five individual-market applicants were either declined or priced out of coverage in the individual market as a result of these underwriting practices.⁴⁵

PPACA erases these differences among insurance markets, as it amplifies the significance of health insurance as a tool to distribute risk.⁴⁶ It does so in two major ways. First, arguably its primary goal—and certainly the most scrutinized—is to insure many of the fifty million⁴⁷ uninsured Americans so that they are included in risk pools. To achieve this goal, PPACA expands public insurance and also reforms private health insurance markets to make insurance more affordable and accessible in several ways. Most obviously, it requires people to carry insurance and thus participate in risk pools through the so-called “individual mandate,”⁴⁸ which spurred challenges to the reform’s constitutionality.⁴⁹ It simultaneously attempts to improve access to insurance by requiring insurers in the individual market to issue policies to all applicants,⁵⁰ requiring many employers to contribute to employee coverage or else pay a penalty,⁵¹ creating state-based “exchanges” to facilitate the sale of insurance to individuals and small

rates that insurers can charge. The Henry J. Kaiser Family Found., *Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)*, 2010, STATEHEALTHFACTS.ORG (data as of Jan. 2010), <http://www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7>; see also discussion *infra* note 255 and accompanying text.

⁴⁵ See SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, PUB. NO. 953, SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN FAMILIES 4 (2006), available at <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2006/Sep/Squeezed-Why-Rising-Exposure-to-Health-Care-Costs-Threatens-the-Health-and-Financial-Well-Being-of.aspx>.

⁴⁶ See generally Baker, *supra* note 6 (describing how PPACA affects risk distribution in both public and private insurance).

⁴⁷ See DENAVAS-WALT ET AL., *supra* note 34, at 71 tbl.C-1 (reporting more than fifty million uninsured Americans in 2009).

⁴⁸ PPACA § 1501, 26 U.S.C.A. § 5000A (West Supp. 1A 2010).

⁴⁹ The mandate is being challenged in a number of federal courts. As of the completion of this Article, five such courts have issued opinions. Three district courts have found PPACA constitutional. See *Mead v. Holder*, No. 10-0950, 2011 WL 611139 (D.D.C. Feb. 22, 2011); *Liberty Univ., Inc. v. Geithner*, No. 10-0015, 2010 WL 4860299 (W.D. Va. Nov. 30, 2010); *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882 (E.D. Mich. 2010); see also Kevin Sack, *A Third Judge Validates Health Care Overhaul Law*, N.Y. TIMES, Feb. 23, 2011, at A14, available at 2011 WLNR 3539819 (discussing the litigation). Two district courts have held PPACA unconstitutional. See *Florida ex rel. Bondi v. U.S. Dep’t of Health & Human Servs.*, No. 10-0091, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011); *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768 (E.D. Va. 2010).

⁵⁰ PPACA sec. 1201, § 2702, 42 U.S.C.A. § 300gg-1.

⁵¹ *Id.* § 1513, 26 U.S.C.A. § 4980H.

groups,⁵² and, for lower-income individuals who do not have access to affordable employer coverage, providing subsidies for purchase of insurance on the individual market.⁵³

Second, PPACA also reforms the individual and small-group markets so that once people are in risk pools, they share risk more evenly, in a manner more like in the large-group markets prior to reform. PPACA extends many of the rules HIPAA applied in group markets to the individual market in order to increase risk pooling. PPACA limits the factors insurers can consider in risk rating.⁵⁴ In addition, all insurers in a state are required to treat all applicants in the individual market as a single risk pool.⁵⁵ Finally, PPACA requires risk-adjustment and reinsurance mechanisms to compensate insurers for writing policies for higher-risk or more costly individuals⁵⁶—practices that are tantamount to facilitating risk-spreading among different insurers' pools.

The result of this private-market reform under PPACA is increased interpersonal distribution of risks within private insurance markets, facilitating what I have discussed in prior work as a more solidaristic health insurance system.⁵⁷ A solidaristic system is one in which risks are pooled equally and broadly among healthy and sick insureds, resulting in "health redistribution," where the healthy help to shoulder the burden of medical care costs for the sick.⁵⁸ Thus, a key goal of PPACA is to reshape insurance markets to enable—and in fact re-

⁵² By January 1, 2014, each state is required to establish an "exchange" to facilitate the purchase of insurance by individuals and small groups. *Id.* § 1311(b), 42 U.S.C.A. § 18031(b) (West Supp. 1B 2010).

⁵³ *Id.* § 1401(a), 26 U.S.C.A. § 36B (West Supp. 1A 2010). With these subsidies, as well as the public insurance reforms that are largely beyond the scope of this Article, what is at stake is not just private insurance and cross-subsidization within a risk pool, but also the use of tax dollars and other revenue to subsidize insurance for lower-income Americans. The distinction between risk-sharing (or cross-subsidization) within insurance pools and subsidization of risk from external sources, such as taxpayers, raises questions about whether Americans are willing to share some risks with those in their risk pool that they are not willing to subsidize for the poor. The sociological and political questions that this distinction raises are good fodder for future examination but are mostly beyond the scope of this Article.

⁵⁴ *See id.* sec. 1201, § 2704, 42 U.S.C.A. § 300gg-4.

⁵⁵ *Id.* § 1312(c), 42 U.S.C.A. § 18032(c) (West Supp. 1B 2010).

⁵⁶ *Id.* §§ 1341–1343, 42 U.S.C.A. §§ 18061–18063.

⁵⁷ The beginnings of private health insurance in the United States were built on a solidarity model. Blue Cross plans exemplified the initial private nonprofit health insurance model, and those plans were community rated so that all insureds in a community paid the same price for coverage and thus shared risks. *See Hoffman, supra* note 5, at 49–51 (discussing these solidaristic roots, their normative bases, and their institutional construction).

⁵⁸ *Id.* at 11–12.

quire—that risks be spread more solidaristically among insureds. PPACA amplifies the importance of the risks that health insurance collectively manages, as it reifies a pluralistic conception of these risks.

II. THREE CONCEPTIONS OF HEALTH INSURANCE

Each of the three dominant American conceptions, or theories, of health insurance has a different vision of which types of risks should be collectively mitigated through the mechanism of insurance. Each theory of health insurance prioritizes mitigating a different type of risk. The first theory posits that the primary goal of health insurance is to mitigate the risk of harms to health; insurance design prioritizes funding care—both preventive and remedial—to maintain or promote health.⁵⁹ I call this the “Health Promotion” theory of health insurance. The second theory posits that the primary goal of health insurance is to mitigate harms to wealth; that is, insurance should be designed in a way that medical costs are covered when they threaten financial security.⁶⁰ I call this theory the “Financial Security” theory of health insurance. The third theory posits that health insurance should prioritize coverage of medical costs that result from unavoidable harms, which are more the result of bad brute luck than of individual behavior.⁶¹ Accordingly, I call it the “Brute Luck” theory of insurance.

This Part describes these three theories and then shows how key policies of PPACA reflect each. The ideas underlying these three theories were at the core of the debates leading up to the passage of PPACA. The quotations introducing the Sections below show both the prominence of these ideas in the debates and the ways in which both parties advanced and adopted these ideas.

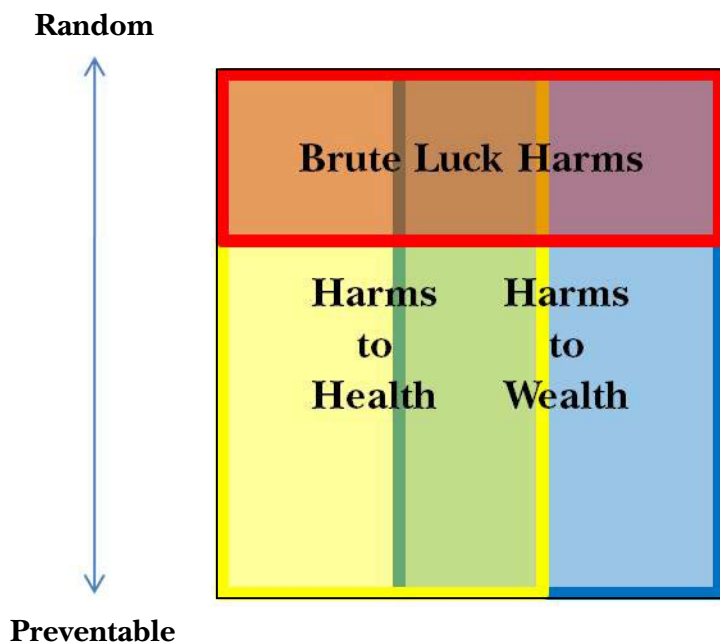
As mentioned earlier, these three theories of health insurance are not mutually exclusive, as illustrated in Figure 1.

⁵⁹ For more information on the Health Promotion theory, see *supra* notes 7-12 and accompanying text.

⁶⁰ For more information on the Financial Security theory, see *supra* notes 13-17 and accompanying text.

⁶¹ For more information on the Brute Luck theory, see *supra* notes 19-22 and accompanying text.

Figure 1: Image of the Three Theories of Health Insurance and Their Overlap



Harms to health can also pose a significant harm to wealth, as illustrated in Figure 1 by the overlap in the column down the middle. And harms resulting from brute luck result in harms to health, wealth, or both. While these three different ways of conceptualizing health insurance are not mutually exclusive, I explain in Part III how tensions arise where their goals or priorities diverge.

As a final preliminary matter, it is possible—and perhaps preferable—that the goals discussed in each of the following Sections could be achieved through mechanisms other than insurance. For example, studies have shown that investments in public health, clean water, education, sanitation systems, and nutrition—or generally ameliorating income inequality—have a larger impact on population health than investments in access to medical care.⁶² Sin taxes on cigarettes or

⁶² According to one scholar,

The broad determinants of health and its distribution in a population include income and wealth, education, political participation, the distributions of rights and powers, and opportunity. . . . We cannot achieve effective promo-

prohibition of smoking in public places might be a better way to encourage people to engage responsibly in risk avoidance. Expanded welfare programs or modified bankruptcy policies are alternative ways to deal with financial insecurity due to high medical care costs. This Article may obscure such alternative—and perhaps in some cases superior—ways to achieve these goals because it instead narrowly addresses the use of *insurance* as a tool to achieve the desired end. Obscuring these alternatives should not be read as diminishing them; rather, this Article simply hones in on insurance because it is the primary tool on which PPACA relies to achieve to such results.

A. *Health Promotion*

And insurance companies will be required to cover, with no extra charge, routine checkups and preventive care, like mammograms and colonoscopies because there's no reason we shouldn't be catching diseases like breast cancer and colon cancer before they get worse.

President Barack Obama⁶³

We don't pay rewards for great management of chronic disease. . . . I'm talking about paying people who actually do a good job to do prevention.

Senator Tom Coburn (R, OK)⁶⁴

1. Theory

The Health Promotion model of health insurance is based on the idea that insurance should protect against harms to health. This idea featured strongly in health reform discussions of policies regarding coverage of preventive services, federally defined mandated health benefits, investments in research to identify high-value services, and investments in primary care and public health infrastructure.

The Health Promotion theory involves two core ideas. First, health insurance should primarily function to foster health by distri-

tion of health in a society as well as its fair distribution without a just distribution of these other goods.

DANIELS, *supra* note 25, at 4; *see also* Elhauge, *supra* note 25, at 1460-61 (discussing the value of investments in nutrition, sanitation, and other alternatives over medical care); Gostin, *supra* note 7, at 14-17 (discussing the significance of infrastructure in prevailing public health problems).

⁶³ Address Before a Joint Session of the Congress on Health Care Reform, 2009 DAILY COMP. PRES. DOC. 693 (Sept. 9, 2009).

⁶⁴ Senator Tom Coburn, Remarks at the White House Health Care Summit (Feb. 25, 2010), transcript *available at* http://www.washingtonpost.com/wp-dyn/content/article/2010/02/25/AR2010022502664_pf.html.

buting the costs of indemnifying against harms to health among all insured. It can do so by using insurance dollars to prevent the onset of illness or injury or to limit the impact of illness or injury that occur.⁶⁵ Second, health insurance should prioritize spending on the most valuable interventions for promoting health. In other words, insurance spending should be cost-effective or high value, with value defined as health benefit gained per dollar spent.⁶⁶ Under this theory, insurance is thus first and foremost a mechanism to pool and redistribute the costs of promoting a healthy population.

These core ideas, when translated into practice, will often mean allocation of spending on more basic interventions and treatment for more people, rather than for intensive treatment for fewer people.⁶⁷ Economists have shown that initial dollars spent on any individual's health are generally high value, in terms of producing positive health outcomes, and in many (but not all) cases, the last dollars spent are low value.⁶⁸ Spending with lower marginal benefit is often called spending on the "Flat of the Curve."⁶⁹ It is not clear exactly which spending is on the flat of the curve, but it is believed that many current health expenditures, particularly for expensive technologies and end-of-life care, fall on it.⁷⁰ It also appears that some people are likely engaged in less valuable spending, while others lack basic care. The average amount spent on care annually per insured American nears \$10,000.⁷¹ And most un-

⁶⁵ See, e.g., Jane Sidorov & Martha Romney, *The Spectrum of Care* (arguing that prevention is a key component of the concept of "population health," or general well-being), in POPULATION HEALTH, *supra* note 7, at 3, 7; see also Gostin, *supra* note 7, at 23 (arguing that insurance encourages more use of health services and thus better health outcomes); Mariner, *supra* note 7, at 447 (noting that "[i]t makes sense to pay for prevention"); Nyman, *supra* note 7, at 142 (arguing that insurance makes expensive procedures more affordable).

⁶⁶ See, e.g., PORTER & TEISBERG, *supra* note 7, at 98 (arguing that "[t]he right objective for health care is to increase value for patients"); Chernew et al., *supra* note 7, at W195-96 (proposing a value-based, rather than cost-based, copayment scheme so as to achieve more efficient outcomes).

⁶⁷ See, e.g., Swartz, *supra* note 8, at 55-56 (arguing that such a system would enable savings from fewer expensive services to fund more basic care).

⁶⁸ Gruber, *supra* note 7, at 582-83 & 583 fig.2 (citing empirical works studying the "causal impact of health insurance on health" and graphing the diminishing marginal value of additional spending in a theoretical "health effectiveness curve").

⁶⁹ *Id.*

⁷⁰ See *id.* at 584 ("Eventually, additional spending does no good in terms of improving health and the effectiveness curve flattens out . . ."); Swartz, *supra* note 8, at 55-56 (advocating for limiting coverage of expensive, ineffective technology).

⁷¹ Health care costs in 2010 are estimated to be just over \$2.5 trillion for just over 250 million insured. CTRS. FOR MEDICARE & MEDICAID SERVS., UPDATED NATIONAL HEALTH EXPENDITURE PROJECTIONS 2009-2019 tbl.1 (2010), available at <https://>

insured Americans receive little to no care.⁷² A Health Promotion model would trade flat-of-the-curve spending for higher-marginal-value spending.⁷³ Dollars would be reallocated from members of a risk pool who would benefit less to those who would benefit more.

Because Health Promotion insurance would be designed to reimburse care for treatments that are deemed most valuable for maintaining or promoting health, it is not deterred by concerns of moral hazard with regard to insurance coverage for such treatments.⁷⁴ The moral hazard principle is the idea that insurance coverage induces people to engage in riskier behavior to the extent insurance indemnifies any harms that may result.⁷⁵ For example, in the case of liability insurance for toxic torts, some are concerned that the very presence of insurance will make polluters less likely to avoid harmful pollution once they are indemnified by insurance.⁷⁶ With respect to health, “moral hazard” refers to insurance both causing people to overuse medical care and causing them to take risks they might have avoided had they been uninsured (e.g., skydiving or entering hot dog eating contests).⁷⁷ Typically, those who are concerned about moral hazard in

www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf; see also DENAVAS-WALT ET AL., *supra* note 34, at 71 tbl.C-1 (reporting more than fifty million uninsured Americans in 2009); Press Release, United States Census, U.S. Census Bureau Announces 2010 Census Population Counts—Apportionment Count Delivered to President (Dec. 21, 2010), available at <http://2010.census.gov/news/releases/operations/cb10-cn93.html> (reporting that the U.S. population on April 1, 2010, was just over 300 million).

⁷² See Gruber, *supra* note 7, at 582 (“There is a clear belief among the public and policymakers that being uninsured is bad for your health.”).

⁷³ Costs of health-promoting medical care would be aggregated and then divided up among the population. We could choose to divide the costs equally so that each American must pay an equal share, or we could choose to allocate costs based upon any other criterion, such as income. Certain premium designs might be more compatible with the goal of protecting against risks to wealth as well, as discussed in Section II.B.

⁷⁴ For an interesting perspective on moral hazard, see generally Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, in EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 52 (Tom Baker & Jonathan Simon eds., 2002).

⁷⁵ See generally Pauly, *supra* note 19 (defining the economics of moral hazard in the context of health insurance and mechanisms employed to reduce the problem).

⁷⁶ See ABRAHAM, *supra* note 19, at 49-50 (noting that an insured with “claims-made coverage” is likely to underestimate the cost of liability compared to the cost of investment in loss prevention).

⁷⁷ See Pauly, *supra* note 19, at 535 (explaining that insurance is considered a “moral hazard” because it lowers the marginal cost of care, thus possibly “increas[ing] [its] usage”); Steven Shavell, *On Moral Hazard and Insurance*, 93 Q.J. ECON. 541, 541 (1979) (“Moral hazard refers here to the tendency of insurance protection to alter an individual’s motive to prevent loss.”).

the health care context are focused on potential overuse and argue for less insurance coverage so that people bear the costs of the care they use and presumably use less care, in turn.⁷⁸ In contrast, a Health Promotion approach aims to encourage people to use more care. This theory rests on the belief that current levels of use of high-value services are too low and that increased use is cost-effective or morally justified. Thus, providing coverage for interventions that are known to promote health (e.g., vaccinations, primary care, and dental care) is intended to increase their use. Insurance can serve as what Deborah Stone has called a “moral opportunity” to define a higher baseline for a community standard of care.⁷⁹

A range of economic and moral arguments could be made in support of health promotion. Before delving into the more tenable arguments, I want to expose the uncertainty of one frequent assumption regarding the role of preventive care in health promotion: namely, that use of preventive care leads to reduced medical care costs. Evidence suggests that that much prevention and early treatment of disease is not cost saving—at either the individual or the system level.⁸⁰ Considered at the individual level, prevention might simply delay the onset of expensive disease. Although some research suggests that preventive care or early detection can create a “compression of morbidity,” reducing the total amount of time that people are sick over a lifetime and thus saving money in care,⁸¹ many studies suggest that it

⁷⁸ See Pauly, *supra* note 19, at 537 (noting that “some uncertain medical care expenses will not and should not be insured in an optimal situation”); Shavell, *supra* note 77, at 541 (describing “incomplete coverage against loss” as a “partial solution to the problem of moral hazard”).

⁷⁹ Stone, *supra* note 74, at 53.

⁸⁰ See LOUISE B. RUSSELL, NAT’L COAL. ON HEALTH CARE, PREVENTION’S POTENTIAL FOR SLOWING THE GROWTH OF MEDICAL SPENDING 8 (2007) [hereinafter RUSSELL, PREVENTION’S POTENTIAL], available at http://www.ihhpar.rutgers.edu/downloads/nchc_report.pdf (“[T]he evidence does not support the commonly accepted idea that prevention always, or even usually, reduces medical costs”; see also LOUISE B. RUSSELL, IS PREVENTION BETTER THAN CURE? 3 (1986) (“[E]ven when the financial cost of the preventative measure looks small, careful evaluation often shows that the full costs are rather large In fact, prevention usually adds to medical expenditures.”). But see Michael V. Maciosek et al., *Greater Use of Preventive Services in U.S. Health Care Could Save Lives at Little or No Cost*, 29 HEALTH AFF. 1656, 1656, 1658 (2010) (noting that others, including Russell, have challenged the idea that preventive care saves money, but finding that certain preventive services may be increased “without an increase in net cost”).

⁸¹ See, e.g., James F. Fries, *Aging, Natural Death, and the Compression of Morbidity*, 303 NEW ENG. J. MED. 130, 132-34 (1980) (showing that as chronic diseases, rather than acute illness, become an increased cause of death, delaying the onset of the disease can reduce the amount of time spent sick with the disease). Chronic diseases are also considered one of the major drivers of health care costs in the United States, account-

simply delays morbidity and, at best, shifts costs from employers to Medicare.⁸² Considered in the aggregate, it is difficult to save money with prevention and diagnostic services because of the economics of disease and medical expenditures. Health care spending is extremely skewed: a small number of people experience high medical care costs in any one year and most experience none.⁸³ In fact, the top five percent of spenders account for over half of medical care costs in the country.⁸⁴ But for the most part, we do not know who will be part of this five percent in a given year. Thus, to identify and stave off expensive disease for the few, we must extend prevention to the many. Even if the per-person costs of prevention are relatively low, the total aggregate costs are high and likely greater than the costs of disease and treatment prevented for the few. For example, if we provide a \$100 diagnostic test to all Americans this year, it will cost \$30 billion.⁸⁵ Even if this test considerably improves the health of 300,000 people, it would have to save an average of \$100,000 in medical care per person to be cost-neutral. Even the top spenders do not typically incur medical care costs as high as \$100,000 in a year.⁸⁶ If this test were wide-reaching and provided benefit for 3 million people (1% of the population), it must still result in savings of \$10,000 per person. Most preventive interventions, including statins for high cholesterol and blood pressure medications, screening tests, and some wellness efforts, are unlikely to have such wide application and generally do not reduce total medical care spending.⁸⁷ Most practitioners agree, however, that preventive care is valuable even if not

ing for as much as seventy-five percent of health care expenditures in 2008. Steven H. Woolf, *The Power of Prevention and What It Requires*, 299 JAMA 2437, 2437 (2008).

⁸² See, e.g., James J. Mongan et al., *Options for Slowing the Growth of Health Care Costs*, 358 NEW ENG. J. MED. 1509, 1512 (2008).

⁸³ See Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures, Revisited*, HEALTH AFF., Mar.-Apr. 2001, at 9, 12 (noting that in 1996, "the top 1 percent of the [U.S.] population accounted for 27 percent of aggregate expenditures"); see also THE HENRY J. KAISER FAMILY FOUND., HEALTH CARE COSTS: A PRIMER 5 (2009), available at http://www.kff.org/insurance/upload/7670_02.pdf ("A small share of people accounts for a significant share of expenses in any year.").

⁸⁴ See Berk & Monheit, *supra* note 83, at 12 (referring to 1996 statistics).

⁸⁵ See Press Release, United States Census 2010, *supra* note 71 (reporting that the U.S. population on April 1, 2010, was just over three hundred million).

⁸⁶ See Berk & Monheit, *supra* note 83, at 13 (noting that in 1996, "the top 1 percent spent \$56,459 per person" on health care costs).

⁸⁷ See RUSSELL, PREVENTION'S POTENTIAL, *supra* note 80, at 4-7 (citing various studies). But see Katherine Baicker et al., *Workplace Wellness Programs Can Generate Savings*, 29 HEALTH AFF. 304, 308 (2010) (finding through a literature survey that workplace wellness programs saved \$3.27 per dollar spent and that absenteeism costs fell by \$2.73 for every dollar spent).

cost saving because it can increase quality of life or extend years of life. As Louise Russell, a leading expert on the subject, has said, "The additional cost may be worthwhile, because it brings better health, but medical spending is not reduced."⁸⁸ Thus, even as some cost savings are possible, the primary justification for Health Promotion insurance is the value or cost-effectiveness of such interventions in improving health and quality of life.

A number of more tenable arguments are based upon the economic and moral value of investments in health improvement. Economic arguments address market failures or individual decision-making errors that are detrimental to health. First, coverage could ameliorate externalities. Both scholars and employers have argued that if insurance promotes health, it has the potential to increase worker productivity and reduce labor costs, eliminating negative externalities of poor health on workplace efficiency.⁸⁹ Investments in increasing health through, for example, mental health coverage or annual flu shots could decrease worker absences and increase overall worker productivity.⁹⁰ In addition, some argue that coverage can address underutilization when insurance encourages individuals to consume services that have individual costs and social benefits, or positive externalities.⁹¹ The classic example is that insurance could cover vac-

⁸⁸ RUSSELL, PREVENTION'S POTENTIAL, *supra* note 80, at 6; *cf.* Nyman, *supra* note 7, at 146 ("There are a number of potential approaches for estimating the value to the consumer of expensive medical procedures.").

⁸⁹ See, e.g., Loeppke, *supra* note 7, at 123 ("The increasing burden of illness and health risk is leading to increased healthcare costs and reduced productivity in the United States . . ."); Woolf, *supra* note 81, at 2437 (referring to a study by Fortune 500 companies showing lost productivity due to smoking (citing 1 CTR. FOR PREVENTION & HEALTH SERVS. & NAT'L BUS. GROUP ON HEALTH, ISSUE BRIEF NO. 5, REDUCING THE BURDEN OF SMOKING ON EMPLOYEE HEALTH AND PRODUCTIVITY (2003), *available at* http://www.businessgrouphealth.org/pdfs/issuebrief_cphssmoking.pdf)).

⁹⁰ See, e.g., Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726, 41,734 (July 19, 2010) [hereinafter Interim Final Rules for Group Health Plans and Health Insurance Issuers] (discussing a study which "found that 69 million workers reported missing days due to illness and 55 million workers reported a time when they were unable to concentrate at work because of their own illness or a family member's illness" (citing KAREN DAVIS ET AL., THE COMMONWEALTH FUND, ISSUE BRIEF, PUB. NO. 856, HEALTH AND PRODUCTIVITY AMONG U.S. WORKERS 1, 2-3 (2005), *available at* http://www.commonwealthfund.org/usr_doc/856_Davis_hlt_productivity_USworkers.pdf)).

⁹¹ See Amy B. Monahan, *Value-Based Mandated Health Benefits*, 80 U. COLO. L. REV. 127, 136-37 (2009) (noting that a mandated health benefit "would be justified where there is evidence of suboptimal utilization" and where "the treatment is sufficiently price-elastic").

cinations to avoid a situation in which too few in a community are vaccinated and everyone becomes more vulnerable to serious illness—the aggregate harms of which are greater than the aggregate of individual costs of vaccination. To deter such inefficient results, insurance coverage creates incentives for individuals to seek out vaccination, lowering barriers to achieving herd immunity.⁹² In a related vein, some have argued that a baseline of health is critical for maintaining a population able to fuel economic prosperity and provide military defense.⁹³ Health insurance could cover services necessary to promote maintenance of such a baseline, however defined.

Second, coverage can counterbalance individual underinvestment in certain services because of decisionmaking errors and biases. Individuals are likely to undervalue certain medical interventions that might stave off future problems (e.g., tests for early detection) if they must bear the cost of such services today for the chance of potential and uncertain benefit in the future.⁹⁴ The inclusion of these services under the umbrella of insurance—particularly if covered with low cost-sharing obligations—can tip the scales toward more efficient use

⁹² States might, of course, also mandate vaccination against certain diseases. For a discussion of modern vaccinations and public health goals, see generally Kevin M. Malone & Alan R. Hinman, *Vaccination Mandates: The Public Health Imperative and Individual Rights*, in *LAW IN PUBLIC HEALTH PRACTICE* 338 (Richard A. Goodman et al. eds., 2d ed. 2007).

⁹³ See, e.g., 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, *SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES* 14 (1983) [hereinafter *SECURING ACCESS TO HEALTH CARE*] (noting that “[i]n the 1st half of the nineteenth century,” health services were driven by the goal of “achiev[ing] a more productive labor force and a healthier general populace for purposes of national defense”); Alan Lyles, *The Political Landscape in Relation to the Health and Wealth of Nations* (describing a finding that a significant percentage of World War I military recruits were unhealthy (citing Stanley Joel Reiser, *The Emergence of the Concept of Screening for Disease*, 56 *MILBANK MEMORIAL FUND Q. HEALTH & SOC.* 403 (1978))), in *POPULATION HEALTH*, *supra* note 7, at 295, 297.

⁹⁴ See Tom Baker & Peter Siegelman, *Tontines for the Invincibles: Enticing Low Risks into the Health-Insurance Pool with an Idea from Insurance History and Behavioral Economics*, 2010 *WIS. L. REV.* 79, 95 (discussing how optimism bias—and the “unfounded belief that bad things will not happen”—leads to underinsurance); Monahan, *supra* note 91, at 140-44 (discussing problems of risk assessment relating to “health insurance purchasing decisions”); Ronald J. Ozminkowski et al., *Predictors of Preventive Service Use Among Medicare Beneficiaries*, *HEALTH CARE FINANCING REV.*, Spring 2006, at 5, 18 (finding that people with better health underuse preventive care). See generally Neil D. Weinstein & William M. Klein, *Resistance of Personal Risk Perceptions to Debiasing Interventions* (describing the persistence of optimism bias in patients’ judgments of their own health risks), in *HEURISTICS AND BIASES* 313 (Thomas Gilovich et al. eds., 2002).

of such services.⁹⁵ While under the Brute Luck theory discussed below, insurance would not cover services that are part of what an informed person should rationally invest in independently to protect her own health, Health Promotion insurance is more concerned with staving off the negative health results of underuse. By increasing use, this approach can lead to social efficiency gains when costs of avoiding poor health are collectivized.

Finally, a number of moral justifications could be made for Health Promotion insurance as a tool for distributive justice.⁹⁶ Some, for example, argue broadly that health is a human right, or a fundamental or primary need, and that access to medical care can help realize this right.⁹⁷ Others articulate more specifically what a right to health would entail, based on particular demands of distributive justice. Norman Daniels contends that health is important as a gateway in life, building on Rawlsian theory to argue that health is necessary to pursue reasonable opportunities or “normal functioning.”⁹⁸ Martha Nussbaum, bringing specificity to the “capabilities approach” she and Amartya Sen have advanced, claims access to “bodily health” is a “central human capability.”⁹⁹ These claims are more expansive than the luck-egalitarian claims discussed below in support of Brute Luck in-

⁹⁵ For a discussion of insurance coverage and elasticity of demand, see *infra* note 106 and accompanying text.

⁹⁶ For an extensive discussion of social-utility and distributive-justice-based arguments for health care, see William W. Fisher & Talha Syed, *Global Justice in Healthcare: Developing Drugs for the Developing World*, 40 U.C. DAVIS L. REV. 581, 602-47 (2007). See also SECURING ACCESS TO HEALTH CARE, *supra* note 93, at 16-20 (“Ethical concern about the distribution of health care derives from the special importance of health care in promoting personal well-being by preventing or relieving pain, suffering, and disability and by avoiding loss of life.”).

⁹⁷ See, e.g., Anja Rudiger, *From Market Competition to Solidarity? Assessing the Prospects of U.S. Health Care Reform Plans from a Human Rights Perspective*, HEALTH & HUM. RTS., no. 1, 2008, at 123, 125-27 (recognizing that the U.S. health reform debate increasingly viewed health care as a “shared responsibility” as opposed to a personal one); Amartya Sen, Comment, *Why and How Is Health a Human Right?*, 372 LANCET 2010, 2010 (2008) (arguing that legislation should be guided by a view of health as a human right); Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the United States*, 95 AM. J. PUB. HEALTH 1156, 1156 (2005) (“Under international law, there is a right not merely to health care but to the much broader concept of health.”).

⁹⁸ See DANIELS, *supra* note 25, at 14 (“Failing to promote health in a population, that is, failing to promote normal functioning in it, fails to protect the opportunity or capability of people to function as free and equal citizens.”).

⁹⁹ Martha C. Nussbaum, *Capabilities as Fundamental Entitlements: Sen and Social Justice*, FEMINIST ECON., nos. 2-3, 2003, at 33, 41. Daniels contends that, in application, capabilities and opportunity largely converge when the goal is to preserve normal functioning. DANIELS, *supra* note 25, at 69-70.

surance because they would restore normal functioning or promote capabilities, regardless of whether the source of the deficit were choice or chance.¹⁰⁰

Others argue that coverage of high-value services could level the inequitable access to medical care between rich and poor Americans.¹⁰¹ Researchers have clearly shown that low socioeconomic status is a determinant of poor health.¹⁰² In other words, someone born into a poor family has a statistically higher chance of facing health problems over her life. Some face a resource constraint that makes obtaining even arguably basic needs, such as “well-child” care and essential pharmaceuticals, difficult if not covered (or only partially covered) by insurance. For example, if a low-income worker is advised to take cholesterol-lowering medication, she is less likely to do so if she must pay for all or part of the cost out of pocket. Better insurance coverage for such inter-

¹⁰⁰ See *id.* at 72 (discussing the difference between the “opportunity for welfare” theory and a view that protects normal functioning).

¹⁰¹ See, e.g., BARACK OBAMA, *THE AUDACITY OF HOPE* 247 (2006) (“[A] plan for universal health-care coverage would do more to eliminate health disparities between whites and minorities than any race-specific programs we might design.”); Gostin, *supra* note 7, at 33-34 (critiquing the U.S. health care system for its barriers to access and resulting negative outcomes that low-income individuals face); Amartya Sen, *Why Health Equity?* (arguing equal access to health care is a part, albeit a small one, of health equity), in *PUBLIC HEALTH, ETHICS AND EQUITY* 21, 22-26 (Sudhir Anand et al. eds., 2004).

¹⁰² The research on “social determinants” of health is considerable. See, e.g., RICHARD WILKINSON & KATE PICKETT, *THE SPIRIT LEVEL* (2009) (showing the effect of income inequality on health); Michael G. Marmot, *Social Differentials in Health Within and Between Populations*, *DAEDALUS*, Fall 1994, at 197 (noting that while mortality rates declined from 1965 to 1990, the disparity in rates between socioeconomic groups grew, suggesting that socioeconomic status could be an important determinant of health); Neil Pearce & George Davey Smith, *Is Social Capital the Key to Inequalities in Health?*, 93 *AM. J. PUB. HEALTH* 122, 122 (2003) (“It has long been established that socioeconomic factors are major determinants of health and mortality.”); Geoffrey Rose, *Sick Individuals and Sick Populations*, 14 *INT’L J. EPIDEMIOLOGY* 32, 38 (1985) (arguing that it is critical to examine both determinants of individual cases of disease as well as incidence rate among a population and concluding that “[c]ase-centered epidemiology identifies individual susceptibility, but it may fail to identify the underlying causes of incidence”); Jennifer Prah Ruger, *Ethics of the Social Determinants of Health*, 364 *LANCET* 1092, 1092-96 (2004) (providing an overview of social-determinants literature and different theories on how to address the problems of health that might be a result of low socioeconomic status); Paul Starr, *The Politics of Therapeutic Nihilism*, *HASTINGS CTR. REP.*, Oct. 1976, at 24, 28 (1976) (“In all age groups, people in lower-income families are reported to be less healthy, sometimes dramatically so.”); Peter Townsend & Nick Davidson, *Introduction to INEQUALITIES IN HEALTH: THE BLACK REPORT?* 13, 20-23 (Douglas Black et al. eds., 1982) (discussing “recent studies . . . filling in our knowledge of the long-term, pervasive effects of class membership on health and development throughout life”); Daniel Wikler, *Personal and Social Responsibility for Health*, 16 *ETHICS & INT’L AFF.* 47, 47 (2002) (cautioning against overemphasizing personal responsibility for health in crafting health policy).

ventions—if deemed high-value—make it more likely that a lower-income insured will be able to use medical care in the same way as her higher-income counterpart.

Finally, insurance can fulfill what some see as a communal, or perhaps religious, obligation to care for others who are ill or injured, or to alleviate the pain some feel from watching others suffer.¹⁰³ Such notions draw from a tradition of medical care as a collective concern of religious communities and professional societies, where these groups ensured the health of members of their community.¹⁰⁴

As discussed further below, each of these above justifications would lead to a somewhat different design of a Health Promotion insurance system. What unites such justifications, though, and what distinguishes them from the justifications offered under the Financial Security or Brute Luck approaches, is the belief that insurance should be designed primarily to increase the use of services that best promote health to achieve any one or more of the above normative goals.

This means that as applied in a Health Promotion system, insurance would be designed to create incentives for increased use of high-value interventions, where the current level of use is considered suboptimal. Motivated by this idea, Michael Chernew and others have promoted a model of “value-based insurance design,” in which coverage and cost-sharing design both creates greater incentives for use of high-value interventions and deters use of lower-value interventions.¹⁰⁵ For example, a high-value intervention might be covered with no cost-sharing obligation (i.e., “first-dollar” coverage) or with relatively low cost sharing. A low-value intervention might not be covered, or might be covered but require the insured to pay high cost-sharing obligations for the service.

¹⁰³ See Elhauge, *supra* note 25, at 1483 (citing “the moral discomfort imposed on others when the poor go without medical treatment” as a reason why we feel obligated to provide health care for those who cannot afford it).

¹⁰⁴ For an examination of the culture of social welfare programs, including health care, in fraternal societies, see generally David T. Beito, *Mutual Aid, State Welfare, and Organized Charity: Fraternal Societies and the “Deserving” and “Undeserving” Poor, 1900–1930*, 5 J. POL’Y HIST. 419 (1993).

¹⁰⁵ See generally Chernew et al., *supra* note 7. Separating out high- and low-value treatments—while perhaps simple in concept—is far from simple in practice. In the health reform debates, the tumult over so-called “death panels” highlights the sensitivity of such determinations. The mere discussion of counseling to help people make rationing decisions with respect to their own care ignited a national backlash to reform. See, e.g., Jim Rutenberg & Jackie Calmes, *Getting to the Source of the “Death Panel” Rumor*, N.Y. TIMES, Aug. 14, 2009, at A1.

Assuming that demand for covered services is elastic¹⁰⁶—when cost has significant influence over what treatments people use—such a design would lead to more use of high-value treatments. Health Promotion insurance relies on the fact that demand is elastic enough that covering health-promoting treatments will increase their use sufficiently to generate the desired health improvements.

Oregon has experimented with value-informed coverage decisions in its Medicaid program, known as the Oregon Health Plan (OHP). The initial goal of the OHP was to provide fewer services to more people, rather than more services to fewer.¹⁰⁷ Oregon developed a rank-order list of over 700 conditions and treatments based on their relative health value, which the state intended to use to ration care by service type.¹⁰⁸ This list now informs an early stage, value-based insurance design plan for the state.¹⁰⁹

¹⁰⁶ Studies show that expanded coverage leads to more utilization overall, but it is difficult to know exactly how elastic the demand is for particular services. See, e.g., JONATHAN GRUBER, *THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND* 9 (2006), available at <http://www.kff.org/insurance/upload/7566.pdf> (discussing various studies revealing information about elasticity of demand for various medical treatments); Monahan, *supra* note 91, at 136 (“A medical service is price elastic when the quantity of the service that is demanded varies markedly and inversely with price. There is evidence that medical care, generally speaking, is price elastic.” (footnote omitted)).

¹⁰⁷ See generally Joan M. Kapowich, *Oregon’s Test of Value-Based Insurance Design in Coverage for State Workers*, 29 HEALTH AFF. 2028 (2010) (describing Oregon’s approach to value-based insurance design); OR. DEP’T OF HUMAN SERVS., *OREGON HEALTH PLAN: AN HISTORICAL OVERVIEW* (2006), available at http://www.oregon.gov/DHS/healthplan/data_pubs/ohpoverview0706.pdf (providing a history of the Oregon plan); see also Somnath Saha et al., *Giving Teeth to Comparative-Effectiveness Research—The Oregon Experience*, 362 NEW ENG. J. MED. e18, e18(2) (2010), <http://www.nejm.org/doi/pdf/10.1056/NEJMp0912938> (explaining that the Oregon Health Service Commission “was charged with setting coverage priorities”). The Oregon Plan’s roots reach back to a 1987 legislative decision to discontinue Medicaid funding of soft-tissue transplants. See OR. DEP’T OF HUMAN SERVS., *supra*, at 1. Controversial rationing decisions are again in the news with Arizona’s recent decision not to fund certain low-success transplants in its Medicaid program. See Kevin Sack, *Arizona’s Medicaid Cuts Are Seen as a Sign of the Financial Times*, N.Y. TIMES, Dec. 5, 2010, at A22 (detailing criticisms of Arizona’s Medicaid spending cuts).

¹⁰⁸ See OR. DEP’T OF HUMAN SERVS., *supra* note 107, at 16 (noting that “[a]s of January 1, 2006, [the Oregon Health Plan] cover[ed] services up through line 530 of the 710 condition treatment pairs on the list.”); Saha et al., *supra* note 107, at e18(3) (presenting a chart with examples at each insurance tier). The highest priority categories of services include maternity care, newborn care, preventive services, and medical or psychotherapy treatment for drug and tobacco abuse. See OR. HEALTH SERVS. COMM’N, *PRIORITIZED LIST OF HEALTH SERVICES* (Oct. 1, 2010), available at <http://www.oregon.gov/OHPPR/HSC/docs/Oct10List.pdf>.

¹⁰⁹ Saha et al., *supra* note 107, at e18(3).

As Oregon learned when the public rejected its initial prioritization list for assigning too little value to certain services,¹¹⁰ the goal of promoting health means different things to different people. The definition of “high value” was intended to guide insurance design, prioritization of treatments, and distribution of spending among subgroups of the population and among different individuals. But what is high value is subjective. Ranking care by relative value can quickly draw ire, as was clearly evinced most recently when health care debates devolved to accusations of “death panels” in the summer of 2009.¹¹¹

In fact, the above moral and economic arguments for general health promotion each would define which interventions are most valuable, based on why health is considered important. Each would imply a different way of prioritizing treatments among a population to serve a particular justicial or economic goal. For example, Norman Daniels would care more about bolstering the future potential health of young people than promoting the health of old people, if health is more critical to preserving normal functioning and lifespan for the young.¹¹² In contrast, a prioritarian might want insurance to promote health for the worst off in society, particularly if their health is poor in the first place

¹¹⁰ In its initial implementation efforts, Oregon announced prioritization decisions that were publicly criticized and altered after being exposed and deemed illogical. For example, the Oregon Health Plan initially prioritized certain treatments simply because they were so inexpensive that they could be administered widely with little cost. The public objected to the placement of such treatments higher on the list than critically important but more expensive treatments. See David C. Hadorn, *Setting Health Care Priorities in Oregon: Cost-Effectiveness Meets the Rule of Rescue*, 265 JAMA 2218, 2218-19 (1991) (documenting the criticism of Oregon’s list, which prioritized headache treatment over some lifesaving measures (citing Timothy Egan, *Problems Could Delay Proposal by Oregon to Ration Health Care*, N.Y. TIMES, July 30, 1990, at A8)); Louis W. Sullivan, Op-Ed, *Oregon Health Plan Is Unfair to the Disabled*, N.Y. TIMES, Sept. 1, 1992, at A16 (criticizing the proposed plan for discriminating against disabled people).

¹¹¹ See Brendan Nyhan, *Why the “Death Panel” Myth Wouldn’t Die: Misinformation in the Health Care Reform Debate*, 8 THE FORUM, Issue 1, art. 5, 2001, at 1, 6-11, <http://www.bepress.com/forum/vol8/iss1/art5/> (explaining how Betsy McCaughey created the prominent “death panel” myth and depicting, in table form, its spread among prominent conservatives throughout the health reform debate); Press Release, Statement by House GOP Leaders Boehner and McCotter on End-of-Life Treatment Counseling in Democrats’ Health Care Legislation (July 23, 2009), available at <https://speaker.house.gov/News/DocumentSingle.aspx?DocumentID=139131> (expressing concern about end-of-life counseling).

¹¹² DANIELS, *supra* note 25, at 179-80; see also Ruger, *supra* note 102, at 1092-94 (discussing the difference between an equality-of-opportunity approach, such as that advocated by John Rawls and Norman Daniels, and an equality-of-results approach, closer to the vision put forth by Amartya Sen, which argues that capabilities must be taken into account in distributional decisions if differences in capabilities could create unequal results even in the face of equal opportunities).

because of a relative lack of access to resources, education, and nutrition.¹¹³ Alternately, insurance would first promote the health of workers in their prime if the driving motivation is economic productivity.

While actualizing the notion of Health Promotion insurance is not simple, the most important point for present purposes is the common thread that undergirds any actualization: health insurance allocation decisions should be made toward the end goal of promoting health. The *primary* goal of health insurance is thus to promote health for Americans by redistributing the costs of the highest-value, health-promoting interventions—however defined—among all insured.

Despite the intuitive appeal to some of the argument that health insurance should aim to improve overall population health by funding high-value care, others question whether this approach is really “insurance” at all. Critics claim that insurance coverage that creates incentives for the use of relatively low-cost preventive or diagnostic service is more like a medical prepayment plan than an insurance plan.¹¹⁴ Such a view presumes a particular function for health insurance that privileges indemnification of individual risks. In contrast, the primary goal of Health Promotion insurance is one of social efficiency, not economic efficiency in the Pareto sense,¹¹⁵ because some may in fact be made worse off to make others healthier. In order to serve many of the goals delineated above, it is necessary to use a collective approach to mitigate harms to health that are socially inefficient. To see indemnification of such losses as insurance requires reframing the risk at hand as a risk to a population as a whole. For example, if we frame the risk as the perpetuation of a suboptimally unhealthy population or an undesirable distribution of health among a population—which

¹¹³ See Persad et al., *supra* note 25, at 424-25 (discussing approaches that are characteristic of a health care system that favors the worst off).

¹¹⁴ See, e.g., JOHN C. GOODMAN & GERALD L. MUSGRAVE, *PATIENT POWER: THE FREE-ENTERPRISE ALTERNATIVE TO CLINTON'S HEALTH PLAN* 24 (1994) (arguing that because there “need not be any risky event to trigger insurance payments,” because the payment is determined by “consumption decisions,” and because the payment is made “not to the insured but to the medical providers,” “health insurance is not insurance at all”); Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251, 276-77 (1973) (advocating the restructuring of health insurance to “reduc[e] its role as a method of prepaying small . . . bills” and to increase its use as a protection against large risks); Pauly, *supra* note 19, at 534-35 (arguing that we do not find “insurance” in pure form for nonrandom, low-risk medical events, such as “visits to a physician’s office” or dental care).

¹¹⁵ For a description of Pareto optimality, see THE MIT DICTIONARY OF MODERN ECONOMICS 324 (David W. Pearce ed., 4th ed. 1992). “When the economy’s resources and output are allocated in such a way that no reallocation can make anyone better off without making at least one other worse off, then a Pareto optimum is said to exist.” *Id.*

could be deemed a problem for any of the economic or moral reasons noted above—we can use insurance as a collective approach to mitigate such a risk. Insurance would do so by allocating dollars toward those harms that pose the greatest risks to overall health or that cause unjust inequities. Furthermore, even if this approach is inconsistent with certain economic conceptions of insurance, it is in reality a function of insurance in operation—a function that is becoming increasingly prominent under PPACA, as I will discuss in the next subsection. Thus, while a Health Promotion theory of insurance is counter-intuitive to those who view insurance as a tool that an individual can use to prevent individual risks to the degree she wants, insurance systems and scholars have long embraced the reality that health insurance could serve collective goals in addition to cushioning individuals against shocks¹¹⁶—the main focus of the next two theories.

2. Health Promotion Policies of PPACA

Health reform debates, not surprisingly, readily embraced the idea that health insurance should promote health.¹¹⁷ A number of the most popular PPACA policies are justified by a Health Promotion conception of health insurance, expanding insurance coverage for services that promise to promote or maintain the health of insureds. These policies are often agnostic to the wealth of recipients of such care and do not treat chance and choice harms differently—the primary concerns of the two theories discussed below. These policies, I contend, have the primary and sometimes sole purpose of collectivizing the costs of selected health-promoting interventions by placing them under the umbrella of insurance coverage.

For example, the law requires all nongrandfathered health insurance plans to cover certain preventive care without any cost sharing,¹¹⁸ effectively distributing the costs of prevention broadly among

¹¹⁶ See, e.g., Richard B. Saltman & Hans F.W. Dubois, *The Historical and Social Base of Social Health Insurance Systems* (emphasizing the importance of solidarity in socialized health care systems in Western Europe), in *SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE* 21, 29 (Richard B. Saltman et al. eds., 2004); Stone, *supra* note 74, at 53 (highlighting the social and public benefits derived from collectively provided insurance). See generally GRAETZ & MASHAW, *supra* note 13 (discussing the role of social insurance in promoting family economic security).

¹¹⁷ See, e.g., Timothy Jost, *Implementing Health Reform: Preventive Services*, HEALTH AFF. BLOG (July 15, 2010, 11:29 AM), <http://healthaffairs.org/blog/2010/07/15/implementing-health-reform-preventive-services/print> (noting the emphasis on preventive care and improving health in PPACA).

¹¹⁸ PPACA sec. 1001, § 2713, 42 U.S.C.A. § 300gg-13 (West Supp. 1A 2010).

insured in such plans (an estimated 78 million Americans by 2013).¹¹⁹ Certain plans were grandfathered, which means that they are excluded from this regulation (and others), but in exchange they can make only very limited changes to their benefits and cost-sharing structures, or else risk losing grandfathered status.¹²⁰ However, all new plans issued after September 23, 2010,¹²¹ must provide first-dollar coverage for preventive care, defined as: (1) “evidence-based items or services” that the U.S. Preventive Services Task Force rates “A” or “B”; (2) immunizations the Centers for Disease Control recommends; (3) “evidence-informed preventive care” and screenings for children, as recommended by the Health Resources and Services Administration (HRSA); and (4) additional preventive care and screenings HRSA supports for women.¹²² Examples include screenings for breast, cervical, and colorectal cancer; alcohol-misuse and tobacco-use counseling; depression screening; and diet counseling for at-risk individuals.¹²³ In March 2011, copayments were similarly eliminated for certain preventive services for Medicare and Medicaid beneficiaries, expanding such policies to an additional population of over 90 million people.¹²⁴ Thus, in sum, PPACA will result in first-dollar coverage of preventive services for nearly 170 million Americans by 2013.

According to the preamble of the recently issued interim final rule on preventive services, eliminating cost-sharing for such services is intended to ameliorate their underuse and expected to result in several health-related benefits.¹²⁵ Because of high turnover in insurance mar-

¹¹⁹ Interim Final Rules for Group Health Plans and Health Insurance Issuers, *supra* note 90, at 41,732. This estimate is based on the total number of individuals in non-grandfathered private health plans by 2013.

¹²⁰ PPACA § 1251, 42 U.S.C.A. § 18011 (West Supp. 1B 2010). The regulations concerning what changes are allowable without losing grandfathered status were recently codified in the Code of Federal Regulations. See Preservation of Right to Maintain Existing Coverage, 45 C.F.R. § 147.40 (2010). For a clear and concise summary of grandfathering, see Timothy Jost, *Implementing Health Reform: Grandfathered Plans*, HEALTH AFF. BLOG (June 15, 2010), <http://healthaffairs.org/blog/2010/06/15/implementing-health-reform-grandfathered-plans>.

¹²¹ PPACA § 1004(a), 42 U.S.C.A. § 300gg-11 note (West Supp. 1A 2010).

¹²² PPACA sec. 1001, § 2713, 42 U.S.C.A. § 300gg-13.

¹²³ See Interim Final Rules for Group Health Plans and Health Insurance Issuers, *supra* note 90, at 41,741-43; Howard K. Koh & Kathleen G. Sebelius, *Promoting Prevention Through the Affordable Care Act*, 363 NEW ENG. J. MED. 1296, 1296-97 (2010).

¹²⁴ PPACA §§ 4104–4108, 42 U.S.C.A. §§ 1395–1396 (West Supp. 1B 2010); see also DENAVAS-WALT ET AL., *supra* note 34, at 71 tbl.C-1 (noting that just over ninety-three million Americans had public health insurance in 2009).

¹²⁵ Interim Final Rules for Group Health Plans and Health Insurance Issuers, *supra* note 90, at 41,733 (“By expanding coverage and eliminating cost sharing for recommend-

kets, insurers lack incentives to invest in preventive services that might have long-term payoff in terms of either cost or customer satisfaction.¹²⁶ In addition, as discussed above, individuals underinvest when they must pay out-of-pocket costs now for benefits that may accrue only later or when they bear costs individually for benefits that accrue to society as a whole.¹²⁷ The regulations state that the intent of the policy is to address these market failures to improve health, reduce absence from work or school, and possibly save some costs.¹²⁸ Thus, the reform requires that insurance fully cover the expense of preventive services for insureds under the belief that doing so will increase use of such services and improve health at large.¹²⁹

Similarly, the Health Promotion notion of insurance undergirds the creation of a category of “essential health benefits” (EHBs).¹³⁰ With the creation of EHBs, PPACA defines a federal floor of mandated health benefits that all new individual and small-group market health plans must now cover, in addition to any existing state mandates above this floor. While Congress left the exact definition of what is an EHB to the Secretary of Health and Human Services (HHS), the categories suggest that EHBs are comprehensive in scope.¹³¹ Further, PPACA directs the Secretary to consider a number of factors in defining EHBs, suggesting a vision of health promotion that values each individual’s health equally in a nondiscriminatory manner.¹³² Namely, PPACA requires the Secretary to “take into account the health care needs of diverse segments of the population, including

ed preventive services, these interim final regulations could be expected to increase access to and utilization of these services, which are not used at optimal levels today.”).

¹²⁶ *Id.* at 41,731.

¹²⁷ *Id.*; see also *supra* notes 94-95 and accompanying text.

¹²⁸ Interim Final Rules for Group Health Plans and Health Insurance Issuers, *supra* note 90, at 41,733.

¹²⁹ For this policy to be effective, insureds must be able to access covered services, which requires that doctors be available at a convenient time and place. In addition, regulators have relied on studies that suggest that the particular services identified for first-dollar coverage are high value. See *id.* at 41,733-34 (explaining anticipated benefits from preventive services based on various studies). These studies must, of course, be correct for this policy to be health-promoting in practice.

¹³⁰ PPACA § 1302, 42 U.S.C.A. § 18022 (West Supp. 1B 2010).

¹³¹ See *id.* § 1302(b)(1), 42 U.S.C.A. § 18022(b)(1) (enumerating categories of essential services, including, but not limited to, emergency services, hospitalization, ambulatory services, maternity and newborn care, mental health and substance-use-disorder services, prescription drugs, rehabilitative services, laboratory services, preventive and wellness services, and pediatric services).

¹³² *Id.* § 1302(b)(4), 42 U.S.C.A. § 18022(b)(1).

women, children, persons with disabilities, and other groups.”¹³³ Furthermore, she must “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.”¹³⁴ These requirements not only explicitly validate the goals of increasing coverage to promote health but also suggest an expansive notion of whose health should be promoted.

PPACA also invests in research that could inform the design of Health Promotion insurance coverage and prioritization of treatments, based upon determination of relative value. PPACA supports work in “comparative effectiveness research” (CER),¹³⁵ a field that aims to determine the relative benefit of medical interventions.¹³⁶ Over a billion dollars in funding was allocated for CER under the American Recovery and Reinvestment Act of 2009.¹³⁷ PPACA establishes a nonprofit non-governmental entity, the Patient-Centered Outcomes Research Institute, to set an agenda for, oversee, and distribute funding for CER.¹³⁸ CER seeks to identify the relative benefits of two interventions or treatments, which could then be weighed against their cost differential.¹³⁹ For example, a physician might treat atherosclerosis through angioplasty or open-heart surgery. CER intends to measure the relative benefit of the two approaches for a patient, taking into consideration differences among individuals and subpopulations.

However, because of objections by those interested in more flexible medical decisionmaking, the use of such CER studies is constrained; for example, PPACA does not require private insurers to use CER to determine benefits structures and prohibits its use for Medi-

¹³³ *Id.* § 1302(b)(4)(C), 42 U.S.C.A. § 18022 (b)(4)(C).

¹³⁴ *Id.* § 1302(b)(4)(B), 42 U.S.C.A. § 18022 (b)(4)(B).

¹³⁵ PPACA, Pub. L. No. 111-148, §§ 6301–6302, 124 Stat. 119, 727-47 (to be codified in scattered sections of 26 and 42 U.S.C.).

¹³⁶ See CONG. BUDGET OFFICE, RESEARCH ON THE COMPARATIVE EFFECTIVENESS OF MEDICAL TREATMENTS: ISSUES AND OPTIONS FOR AN EXPANDED FEDERAL ROLE 3-7 (2007), available at <http://www.cbo.gov/ftpdocs/88xx/doc8891/12-18-ComparativeEffectiveness.pdf> (providing examples of comparative effectiveness studies). See generally Lynn M. Etheredge, *Creating a High-Performance System for Comparative Effectiveness Research*, 29 HEALTH AFF. 1761 (2010) (recommending ways to improve comparative effectiveness research (CER)); John K. Iglehart, *Prioritizing Comparative-Effectiveness Research—IOM Recommendations*, 361 NEW ENG. J. MED. 325 (2009) (discussing the Institute of Medicine’s release of a “report recommending a portfolio of 100 study topics” for CER).

¹³⁷ Pub. L. No. 111-5, 123 Stat. 115 (codified in scattered sections of U.S.C. (2006 & Supp. III 2009)); see also Iglehart, *supra* note 136, at 325 (“The ARRA included \$1.1 billion for CER . . .”).

¹³⁸ PPACA sec. 6301, § 1181(b), 42 U.S.C.A. § 1320e(b) (West Supp. 1A 2010).

¹³⁹ See *supra* note 136 and accompanying text (describing CER).

care coverage decisions in a wide range of circumstances, especially when considered in conjunction with cost data (i.e., comparative value).¹⁴⁰ To the extent CER results do not influence insurance design, for CER to translate effectively into practice in a way that drives increased value, the research must enable providers to have accurate evidence on the relative benefits (and costs) of interventions and practices, and providers must be willing to act on such evidence. Perhaps as high of a hurdle, Americans must accept using cost-effectiveness data to guide rationing decisions. If a checkup every five years yields 80% of the value of annual checkups at 20% of the cost, will Americans and their physicians acquiesce to checkups every five years? Or will they pursue the 20% of remaining value from the annual checkups? PPACA thus sets the stage for more precisely designed Health Promotion insurance through CER, but it does not preordain that the results of such research will shape future health care financing and delivery.

Finally, while not directly related to insurance reform, PPACA calls for significant investment in prevention and primary health infrastructure. In a recent article in the *New England Journal of Medicine*, Assistant Secretary of Health Howard Koh and Secretary of HHS Kathleen Sebelius expressed a belief that the law signals a new era of prevention:

Many of the 10 major titles in the law, especially Title IV, Prevention of Chronic Diseases and Improving Public Health, advance a prevention theme through a wide array of new initiatives and funding. As a result, we believe that the Act will reinvigorate public health on behalf of individuals, worksites, communities, and the nation at large . . . and will usher in a revitalized era for prevention at every level of society.¹⁴¹

Some of the goals of prevention will be met through policies that bolster primary care delivery structures by increasing reimbursements for such care and creating incentives for new physicians to enter into the field of primary care.¹⁴² Through these investments in public

¹⁴⁰ PPACA sec. 6301, § 1182, 42 U.S.C.A. § 1320e-1. For a discussion on implementing the results of CER, see, for example, Aanand D. Naik & Laura A. Petersen, *The Neglected Purpose of Comparative-Effectiveness Research*, 360 NEW ENG. J. MED. 1929 (2009), and James C. Robinson, *Comparative Effectiveness Research: From Clinical Information to Economic Incentives*, 29 HEALTH AFF. 1788, 1792-93 (2010). PPACA also raised concerns that developing generalized rules might undermine both consideration of variable patient responses and physician autonomy. See John K. Iglehart, *The Political Fight over Comparative Effectiveness Research*, 29 HEALTH AFF. 1757, 1757-59 (2010) (explaining how CER sent "conservative pundits . . . into rhetorical overdrive").

¹⁴¹ Koh & Sebelius, *supra* note 123, at 1296.

¹⁴² See Kevin Sack, *Health Care Wastefulness Is Detailed in Studies*, N.Y. TIMES, Sept. 7, 2010, at A15.

health and primary care infrastructure and the abovementioned coverage expansions for preventive care and EHBs, PPACA intends to reform health care insurance and delivery systems in a way justified by a Health Promotion theory of insurance, even to the extent doing so might undermine other visions of insurance within the law, as discussed below in Section III.D.

B. *Financial Security*

Everyone understands the extraordinary hardships that are placed on the uninsured, who live every day just one accident or illness away from bankruptcy.

President Barack Obama¹⁴³

The underinsured are a critical group In some cases 53 percent don't know they're underinsured. So they either have a huge co-pay if the problem happens or the deductibles being [sic] so high they might as well not have insurance.

Senator Chris Dodd (D, CT)¹⁴⁴

1. Theory

An alternate view that captured the imagination of scholars, policy-makers, and the public and that wove strongly through reform debates is that insurance should primarily serve to protect against risks to wealth. Stated otherwise, the goal of health insurance is to prevent the costs of medical care from causing financial insecurity.¹⁴⁵ This Financial Security vision of insurance underlies other key PPACA policies, including the elimination of policy limits, a cap on cost sharing

¹⁴³ Address Before a Joint Session of the Congress on Health Care Reform, *supra* note 63.

¹⁴⁴ Michelle Miller, *25 Million Have Health Insurance But Not Enough*, CBSNEWS.COM (July 26, 2009), <http://www.cbsnews.com/stories/2009/07/26/eveningnews/main5189708.shtml>.

¹⁴⁵ See, e.g., Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 959 (1963) ("If we think of utility as attached to income, then the costs of medical care act as a random deduction from this income, and it is the expected value of the utility of income after medical costs that we are concerned with."); see also *supra* notes 13-17 and accompanying text (introducing the Financial Security theory). Policymakers and scholars often propose catastrophic plans to translate this idea into practice. While a logical extension of the theory to the extent they protect individuals from especially high expenditures and reduce moral hazard, these plans have been criticized for causing health insecurity in practice by imposing high deductibles and cost-sharing on low- and middle-income workers unable to manage such costs. See HACKER, *supra* note 14, at 149-53 (describing plans to cut back insurance coverage to encourage efficient and cost-effective use of medical services).

for all insureds, and subsidies of premiums for lower income Americans, as discussed below.¹⁴⁶ Although many interested in insurance as protection against financial risk would certainly also expect that insurance promote health, the difference is that, for them, the *primary* goal that defines priorities for redistribution and drives resource allocation decisions is prevention of financial insecurity. Under this theory, insurance is thus a mechanism to pool and redistribute costs of care that would cause the insured undue financial burden.

This model differs from a Health Promotion model in two key ways. First, this model has a more flexible notion of what services a policy might cover. While the Health Promotion model relies on a particular insurance design that creates incentives for the use of high-value interventions, a Financial Security model can be more *laissez faire* about the particular design of a policy. To be meaningful, health insurance policies must still provide a baseline of coverage and access to medical care that likely would have similarities to the coverage offered in a Health Promotion model of insurance.¹⁴⁷ But policies could be designed with more variability around and above this baseline, even among policies with the same price and actuarial value.¹⁴⁸ For example, one policy might privilege greater certainty, covering more expensive diagnostic care in the case of injury or illness. Another might favor health care choice or geographical flexibility. Another could cover heroic end-of-life care instead of preventive care. All of these emphases are consistent with a Financial Security approach, and insureds could choose insurance protection that indemnifies the types of losses and pays for the types of care most important to the insureds themselves.

The second and more significant difference concerns the allocation of insurance dollars. Regardless of what a policy covers, at what point will it indemnify losses? In this second model, expenses are indemnified based on whether they pose a significant financial threat, not necessarily based on the relative value of the services for promoting health.¹⁴⁹ Even if a Financial Security policy covered preventive care or early detection screening, it would prioritize indemnifying the

¹⁴⁶ See *infra* notes 178-93 and accompanying text.

¹⁴⁷ This baseline is particularly important to the degree it defines the contours of policies that are subsidized. Otherwise, "affordable" could translate into poor coverage and increased risks of financial vulnerability from out-of-pocket medical care costs down the line.

¹⁴⁸ Others could choose to buy into more comprehensive policies. They would simply pay more for such coverage if they valued it and could afford it.

¹⁴⁹ Such a policy, however, will in all likelihood also pay for many high-value services.

costs of using such care only once such use becomes unaffordable to the insured. Furthermore, a Financial Security policy is likely to indemnify more flat-of-the-curve spending.¹⁵⁰ Catastrophic spending—which poses the most obvious financial threat—likely falls on the flat of the curve in some instances because it is so expensive that the dollar per benefit is lower than for other less expensive, and equally, or even less, beneficial interventions.

Scholars, politicians, and others in popular discourse have advanced this notion of health insurance both explicitly and implicitly. In their 1999 book *True Security*, Professors Michael Graetz and Jerry Mashaw advocate for an American social insurance system that provides Americans with security against a life cycle of risks to income.¹⁵¹ Graetz and Mashaw write that social insurance should “be designed to protect income adequacy and to support income stability in the face of large and unpredictable medical expenses, as well as to guard against loss of income due to illness.”¹⁵² They identify two major threats against which insurance should provide a cushion: high costs of medical treatment and a possible loss of wages during recovery from illness or injury.¹⁵³ Thus, according to Graetz and Mashaw, health insurance should distribute the costs of expensive medical treatment, especially large and unpredictable medical expenses, that would threaten income adequacy or security.

Although Graetz and Mashaw are particularly concerned with social insurance, a rich literature has developed to expose how and contend that private insurance has failed to provide sufficient financial security in a number of ways.¹⁵⁴ Some of the most prominent academic work in this vein is a series of studies by Professors David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, which suggests that medical care expenses are a cause of bankruptcy in a significant number of bankruptcy filings.¹⁵⁵ While some of the subjects in these studies were uninsured, three-quarters of those filing for medical bankruptcy, according to one study, were actually insured

¹⁵⁰ For more information on “flat-of-the-curve” spending, see *supra* note 69 and accompanying text.

¹⁵¹ GRAETZ & MASHAW, *supra* note 13.

¹⁵² *Id.* at 170.

¹⁵³ *Id.*

¹⁵⁴ See *supra* note 14 and accompanying text.

¹⁵⁵ See Himmelstein et al., *Illness and Injury*, *supra* note 14, at W5-70 (“[M]edical problems contribute to about half of all bankruptcies.”); Himmelstein et al., *Medical Bankruptcy*, *supra* note 14, at 743 (finding that “[i]llness or medical bills contributed to 62.1% of all bankruptcies in 2007”).

at the time of filing, which suggests that private coverage—as currently designed—is insufficient to provide income security.¹⁵⁶ Melissa Jacoby and Mirya Holman build on this work by showing that prior studies underestimated medically related bankruptcies because they relied on court records that categorized credit card debt and mortgage debt as nonmedical, even if this debt were incurred to pay for medical care.¹⁵⁷ Using a similar approach to study foreclosures, another study found medical costs were a key driver of foreclosures, even for the insured.¹⁵⁸ While bankruptcy can be an efficient way to address financial trouble in a limited scope, the above studies imply that the current level of medical bankruptcy and foreclosure in the United States is a problem caused in part by insufficient insurance coverage.

Finally, Jacob Hacker has documented what he calls the “Great Risk Shift”—namely the increasing financial risk that Americans have faced over the past several decades due, in part, to rising medical costs in conjunction with the design of private insurance, which causes Americans to bear more of these costs.¹⁵⁹ He argues that this trend of “risk privatization,” in contrast to “risk socialization,” has occurred through policy drift, whereby “otherwise stable policies” have resulted in greater insecurity in light of changing circumstances.¹⁶⁰ For example, he attributes a rising trend of uninsurance to the cost of medical care “outstripping” wage growth, making it impossible for workers and employers to finance insurance.¹⁶¹ In the face of high medical-cost growth and lower wage growth, even policies that on their face do not change become unaffordable. Paying just for premiums (regardless of medical care use) might create concerns of financial insecurity. The theme of all of these studies is that Americans—even those with insurance—are at high and unacceptable levels of financial risk due to costs of health insurance and medical spending. Impliedly, policies

¹⁵⁶ Himmelstein et al., *Medical Bankruptcy*, *supra* note 14, at 743.

¹⁵⁷ Jacoby & Holman, *supra* note 14, at 242.

¹⁵⁸ See Christopher Tarver Robertson et al., *Get Sick, Get Out: The Medical Causes of Home Mortgage Foreclosures*, 18 HEALTH MATRIX 65, 66 (2008) (stating that up to 1.5 million Americans are at risk of losing their homes due to medical costs).

¹⁵⁹ HACKER, *supra* note 14, at 7. But see Jonathan Gruber & Helen Levy, *The Evolution of Medical Spending Risk*, J. ECON. PERSP., Fall 2009, at 25, 44 (“Our bottom line is that health spending risk facing a typical household has not increased much, if at all, since 1980.”).

¹⁶⁰ HACKER, *supra* note 14, at 248-49.

¹⁶¹ *Id.* at 252-53 (citing Richard Kronick & Todd Gilmer, *Explaining the Decline in Health Insurance Coverage, 1979-1995*, HEALTH AFF., Mar.-Apr. 1999, at 30).

better designed to protect Americans against these harms are therefore key to financial security.

Translating this theory into insurance policy design requires consideration of two types of spending. First, insurance based upon the Financial Security notion would aim to cabin out-of-pocket spending on medical care once such spending might make someone financially insecure. Individuals incur several types of out-of-pocket costs when they use medical care. For example, they pay for cost-sharing requirements (like deductibles, coinsurance, and copayments) under an insurance policy for treatments not covered by insurance and for care beyond policy limits. Such costs may be substantial if the insured is very sick, seriously injured, or not well insured, contributing to bankruptcy and foreclosure, as noted above. Under a Financial Security approach, an insured would be expected to contribute to medical expenses to the extent affordable.¹⁶² Such a policy reduces moral hazard. In other words, by paying some of the costs of the care they use, insureds have greater incentives to reduce unnecessary use of medical care.¹⁶³ But at the point that medical care costs pose financial risk, insurance would begin to indemnify spending. Second, according to Financial Security notions, premiums for policies with meaningful coverage must be affordable in the first place. Depending on an individual's income and wealth, even routine premium contributions may be unmanageable. Thus, ensuring financial security requires consideration of both out-of-pocket spending on care and on premium contributions.

Again, as in the case of Health Promotion insurance, this theory could be interpreted into policy in various ways. Advocates of this approach could draw lines and design coverage differently depending on what they consider to constitute "financial insecurity." Financial insecurity could be measured by a shock to disposable income available after medical care costs or by depletion to assets. It could be gauged over a short time frame, or over multiple years, or over a lifetime.

¹⁶² Cf. GRAETZ & MASHAW, *supra* note 13, at 174 ("Because this system guarantees against larger than bearable individual or family medical expenditures, the primary funding source—the first payor—for medical care will be individuals.").

¹⁶³ While requiring insureds to contribute to medical care out of pocket might curb unnecessary spending, the concomitant risk is that some will underuse valuable health services. As revealed by the RAND Health Insurance Experiment, when they are required to pay for medical care, some individuals will forgo care, even when this forbearance is not in their best interests. The study showed people were as likely to forgo highly cost-effective care as marginally cost-effective care. GRUBER, *supra* note 106, at 4.

Graetz and Mashaw suggest a two-part test to measure financial insecurity: the risk of falling below a “decent” income level and the risk of an “unacceptably steep decline in living standards” due to large medical expenses.¹⁶⁴ The first requires determining what constitutes a decent income level below which an individual would neither be expected to pay premiums for insurance nor share in the costs of medical care. Above that decent income level, an insured would contribute to insurance premiums and medical costs, perhaps on a sliding-scale basis adjusted to keep an insured from slipping back under a line of decent income after making premium payments. One could also consider decent income over a longer time period, factoring in an ability to borrow to cover expenses that are unaffordable this year but could be financed through future earnings.¹⁶⁵ Furthermore, one could consider medical expenses in light of total household expenses, based on factors such as geographic cost of living, family size, or nonmedical debt that might make shifting dollars to medical care easier for one household than for another.¹⁶⁶ PPACA premium subsidies, as discussed below, follow a simple version of this approach by determining affordability based upon annual income.

A measure of financial security becomes much more complicated if a decline in living standards can constitute insecurity. A decline might be measured, for example, based on what share of income individuals devote to medical care expenses or based on depletion of assets. If 10% were the standard, for example, someone who earns \$40,000 per year would have to spend \$4000 out of pocket before becoming “insecure,” while someone who earns \$300,000 would have to spend \$30,000. Or higher earners might be required to spend a higher per-

¹⁶⁴ GRAETZ & MASHAW, *supra* note 13, at 171.

¹⁶⁵ Looking at annual income, costs may appear unaffordable. But looking only at one year may be myopic. If someone could finance high medical care costs this year from a one-time shock (e.g., a heart attack or an accident) over the next few years through a loan, this shock might not be deemed to create financial vulnerability. Likewise, if premiums are unaffordable this year for someone whose income will skyrocket next year when she finishes school and begins work, perhaps she should borrow to finance this year’s premiums. If measured over a longer time horizon, costs would constitute a valid threat to financial security only when a shock is large enough that an insured (1) cannot afford to finance it through a loan, even considering future income; (2) cannot obtain credit at a manageable rate; or (3) cannot shift costs forward because they are recurring at a level high enough (e.g., chronic disease) to pose persistent financial risk.

¹⁶⁶ The federal poverty level tables, for example, take family size into account. *See* Delayed Update of the HHS Poverty Guidelines for the Remainder of 2010, 75 Fed. Reg. 45,628, 45,629 (Aug. 3, 2010) [hereinafter 2010 HHS POVERTY GUIDELINES].

centage of income before they are deemed “insecure.” Under a pure income test, an heiress earning \$40,000 a year would receive subsidies if under the income threshold (as, in fact, would be true in the case of PPACA’s subsidy policy on its face¹⁶⁷) but would certainly not if assets were considered. Taking assets into account would provide greater precision but would be nearly impossible to administer, requiring a more nuanced way to account for the presence and depletion of non-income assets for all Americans.¹⁶⁸

In sum, translating a Financial Security theory into policy requires defining financial security so that insurance can be designed to ensure that no one risks compromised financial security due to medical care costs. While supporters of this theory might disagree on what exactly constitutes financial insecurity, the thread that defines this theory and unites its supporters is a belief that, at its core, health insurance should primarily serve to protect financial security, however defined, by pooling and redistributing costs that might otherwise compromise any individual’s security.

2. Financial Security Policies of PPACA

This Financial Security conception of health insurance informs several of the key PPACA policies that cabin possible financial exposure from medical care expenses and premium costs. For example, PPACA requires that all health plans limit total annual cost-sharing obligations.¹⁶⁹ These limits are defined according to the Internal Revenue Code section on out-of-pocket maximum allowable amounts for high-deductible health plans,¹⁷⁰ which were \$5950 for individual coverage and \$11,900 for family coverage in 2010, adjusted annually for cost of living.¹⁷¹ Because of the broad application of these cost-sharing limits to all plans, including self-insured plans, this rule will benefit all

¹⁶⁷ PPACA § 1401(a), 26 U.S.C.A. § 36B (West Supp. 1A 2010).

¹⁶⁸ Assets are already considered, however, in the provision of Medicaid in most states. For example, to the extent that someone with a low income has spent down her assets and needs long-term care, she will qualify for Medicaid in most states. For background on Medicaid eligibility, see *Medicaid Eligibility Overview*, CENTERS FOR MEDICARE & MEDICAID SERVICES, http://www.cms.gov/medicaideligibility/01_overview.asp (last modified Nov. 1, 2010) [hereinafter *Medicaid Eligibility Overview*].

¹⁶⁹ PPACA § 1302(c), 42 U.S.C.A. § 18022(c) (West Supp. 1B 2010).

¹⁷⁰ See PPACA § 1302(c), 42 U.S.C.A. § 18022(c); see also I.R.C. § 223(c)(2)(A)(ii) (2006).

¹⁷¹ INTERNAL REVENUE SERV., DEP’T OF THE TREASURY, NO. 969, HEALTH SAVINGS ACCOUNTS AND OTHER TAX-FAVORED HEALTH PLANS 3 (2010), available at <http://www.irs.gov/pub/irs-pdf/p969.pdf>.

insureds. This means that all annual out-of-pocket insured medical care expenses above these levels will be financed by insurance and distributed among members of an insurance pool.

This rule relies upon a blunt definition of financial security, rather than on one of the more nuanced approaches discussed above.¹⁷² Instead of tailoring unacceptable out-of-pocket exposure based on individual income or assets, it applies an across-the-board policy that no one should spend more than a certain set amount per year, out of pocket, on care.¹⁷³ While more administrable, such a policy errs in the direction of providing excessive security for some and risking insufficient security for others, depending on how one defines financial security. Consider how this policy applies to the average U.S. household. According to the U.S. Census, the median household income in 2009 was just over \$50,000, a slight decrease from 2008.¹⁷⁴ In 2010, the average employee premium contribution for family ESI coverage was \$4000,¹⁷⁵ about 8% of household income.¹⁷⁶ If the family has significant medical care needs in a year and incurs \$11,900 in cost sharing, it would spend nearly a third of annual household income on medical expenses.¹⁷⁷ These limits thus lessen financial exposure, as intended, but still require meaningful contribution to medical care costs.

An additional key Financial Security policy is the creation of sliding-scale tax subsidies for insurance premiums and sliding-scale cost-sharing obligations for those who buy insurance in the individual

¹⁷² See *supra* notes 164-68 and accompanying text.

¹⁷³ Care not covered by a policy would fall outside of these limits.

¹⁷⁴ AMANDA NOSS, U.S. CENSUS BUREAU, NO. ACSBR 09-2, HOUSEHOLD INCOME FOR STATES: 2008-2009, at 1 (2010), available at <http://www.census.gov/prod/2010pubs/acsbr09-2.pdf>.

¹⁷⁵ THE HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY 76 (2010) [hereinafter KFF & HRET 2010 SURVEY], available at <http://ehbs.kff.org/pdf/2010/8085.pdf>.

¹⁷⁶ Because the population that is offered employer-sponsored insurance is likely to have a higher median income than the U.S. median of \$50,000, the average percentage of income paid for premiums might be slightly lower. In addition, the KFF & HRET Survey reports only averages, not medians, so the median premium price, which would provide a better apples-to-apples comparison, might be either higher or lower than \$4000. Nonetheless, 8% is a ballpark estimate.

¹⁷⁷ Furthermore, out-of-pocket limits apply only to what the plan covers. If any family member needs care that falls outside of the scope of the policy, an insured must finance such care completely out of pocket. If a family incurred such costs in any one year, it might be able to finance them over a number of years. However, if such costs recur due to chronic disease or other long-term health problems, they might be unaffordable.

market.¹⁷⁸ These premium subsidies, the details of which were hotly debated, were finalized in HCERA, which increased the scope of subsidies from the initial Senate bill.¹⁷⁹ The subsidies are designed so that someone earning up to 400% of the federal poverty level (FPL) is expected to spend only a certain percentage of income on premiums, ranging from 2% of income for someone earning 133% of the FPL to 9.5% of income for someone earning 300% to 400% of the FPL.¹⁸⁰ Subsidies are calculated based on the difference between the premium price for a plan and the percentage of income an individual is expected to spend. Because premiums vary based on the richness of benefits, subsidies are determined based on an average plan premium, defined as the second-lowest-cost “silver level” plan in the region (i.e., plans with an actuarial value of 70% or higher).¹⁸¹ For example, an individual who earns \$1210 a month (or \$14,520 a year) earns just above 133% of the FPL.¹⁸² She is expected to spend 3% of her income on premiums, or about \$36 per month. If the silver level plan in her region costs \$200 per month, she is eligible for \$164 in premium support.¹⁸³ As she earns more, she contributes more, based upon the presumption that she can do so without becoming financially insecure. These premium credits are generously indexed to reflect excess premium growth over income growth, so that their impact will

¹⁷⁸ See HCERA, sec. 1001(a), § 1401(a), 26 U.S.C.A. § 36B(b)(3)(A) (West Supp. 1A 2010); PPACA § 1402, 42 U.S.C.A. § 18071 (West Supp. 1B 2010).

¹⁷⁹ The House Bill provided more generous subsidies than the Senate Bill. See Affordable Health Care for America Act, H.R. 3962, 111th Cong. §§ 342–344 (as passed by the House on Nov. 7, 2009). The level of subsidies was a significant sticking point toward the end of the legislative process. HCERA struck a compromise by increasing the potential subsidies so that, in some cases, the subsidies are now more generous in the final law than in the House Bill. See HCERA sec. 1001(a), § 1401(a), 26 U.S.C.A. § 36B(b)(3)(A) (West Supp. 1A 2010). For a side-by-side comparison of premium subsidies in the House and Senate Bills, see SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, PUB. NO. 1343, THE HEALTH INSURANCE PROVISIONS OF THE 2009 CONGRESSIONAL HEALTH REFORM BILLS: IMPLICATIONS FOR COVERAGE, AFFORDABILITY, AND COSTS, at ix, exhibit ES-1 (2010), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Jan/Coverage%20Report/1343_Collins_cong_bills_coverage_report_172010.pdf.

¹⁸⁰ HCERA sec. 1001(a), § 1401(a), 26 U.S.C.A. § 36(b)(3)(A).

¹⁸¹ See PPACA § 1302(d)(1)(B), 42 U.S.C.A. § 18022(d)(1)(B) (West Supp. 1B 2010) (defining a silver level plan); *id.* § 1401, 26 U.S.C.A. § 36B(b)(2) (West Supp. 1A 2010) (defining the calculation of the “premium assistance credit amount”).

¹⁸² See 2010 HHS POVERTY GUIDELINES, *supra* note 166, at 45,629.

¹⁸³ HCERA sec. 1001(a)(1), § 1401(a), 26 U.S.C.A. § 36B(b)(3)(A). This presumes that her plan covers only the essential health benefits and does not include additional state requirements, the cost of which are excluded for the calculation of tax credits. See PPACA § 1401(a), 26 U.S.C.A. § 36B(b)(3)(D).

not erode in future years with medical cost inflation.¹⁸⁴ This adjustment will be considerable if the trend of the U.S. premium's growth above inflation levels continues. From 2000 to 2009, ESI premiums grew an average of 5.1% per year, as compared to a 0.7% wage growth.¹⁸⁵

Additionally, for those who earn between 100% and 400% of the FPL and who buy a silver plan through a state exchange, or clearing-house set up under the law for the sale of insurance,¹⁸⁶ the law further lowers the cost-sharing limits discussed above. For example, the limits for someone earning 200% to 300% of the FPL are half the limits discussed above (or just under \$3000 per individual and \$6000 per family).¹⁸⁷

These premium tax credits and reduced cost-sharing provide significant protection against financial risk to those who buy insurance on an exchange, but the policy's design limits this protection in two regards. First, subsidies are available only for policies bought on a state exchange, not for insureds with ESI. To prevent employees from declining plans offered by employers so that they can buy subsidized policies on the exchange instead, the law does not authorize subsidies to anyone who has *access* to "affordable" and adequate minimum essential coverage through other sources.¹⁸⁸ Such coverage is deemed unaffordable only if premiums cost over 9.5% of income and inadequate if the actuarial value of the plan is less than 60%.¹⁸⁹ This limitation means that someone whose employer offers coverage might remain more financially vulnerable than a similarly situated individual whose employer does not offer coverage.¹⁹⁰ Thus, these limits provide relief to the family discussed above at risk of spending one-third of gross income on medical expenses, but only if this family is among the

¹⁸⁴ HCERA sec. 1001(a)(1)(B), § 1401(a), 26 U.S.C.A. § 36B(b)(3)(A)(ii)(I).

¹⁸⁵ Wage growth is calculated net of the employee's share of health benefits. See Christina Romer & Mark Duggan, *Exploring the Link Between Rising Health Insurance Premiums and Stagnant Wages*, COUNCIL ECON. ADVISORS (Mar. 12, 2010, 12:17 PM), <http://www.whitehouse.gov/blog/2010/03/12/exploring-link-between-rising-health-insurance-premiums-and-stagnant-wages>.

¹⁸⁶ By January 1, 2014, each state is required to establish an "exchange" to facilitate the purchase of insurance by individuals and small groups. PPACA § 1311(b), 42 U.S.C.A. § 18031(b) (West Supp. 1B 2010).

¹⁸⁷ *Id.* § 1402(c)(1)(A)(ii), 42 U.S.C.A. 18071(c)(1)(A).

¹⁸⁸ *Id.* § 1401(a), 26 U.S.C.A. § 36B(c)(2)(C) (West Supp. 1A 2010).

¹⁸⁹ HCERA sec. 1001(a)(2), § 1401(a), 26 U.S.C.A. §§ 36B(c)(2)(C)(i)–(ii).

¹⁹⁰ There is speculation as to whether employers will drop coverage so that employees can buy through exchanges, despite the penalties these employees would face through the employer mandate. Conversation with Amy Monahan, Professor, Univ. of Minn. Law Sch. (Sept. 27, 2010).

minority of American families who will obtain coverage on an exchange, rather than through an employer.¹⁹¹ In addition, by using a silver plan to set subsidies, PPACA effectively determines that once tax dollars are used to bolster financial security in the face of medical expenses through subsidies, the level of protection is defined with respect to services covered under an average silver plan. Under this policy, if someone invests in uncovered services, she does so at her own financial peril. Lifting the ESI restrictions or allowing subsidies for “platinum plans” (i.e., plans with an actuarial value of 90% or higher¹⁹²) would enhance the reach of financial protection under the law to spending on more coverage or services. But doing so would also increase the total cost of subsidies and could draw funds toward ensuring financial security and away from competing policy goals.¹⁹³

Another security-enhancing policy, which became effective on September 23, 2010, is the prohibition of lifetime insurance policy limits and a gradually phased-in elimination of annual limits on “essential benefits.”¹⁹⁴ A health plan could previously cap the total losses the policy would cover, either annually or in total over the lifetime of the policy for a subscriber. According to one study, prior to PPACA, about 55% of employer plans were subject to lifetime spending limits, most commonly set at \$1 million or \$2 million.¹⁹⁵ Furthermore, at the time of the study, approximately 20,000 to 25,000 individuals had exceeded these limits in their current health plans.¹⁹⁶ This means that these individuals had already incurred over \$1 million or \$2 million in covered medical care over the lifetime of a currently held plan. Such individuals presumably have significant health needs if they have exceeded the limit in the first place. Once they exceed policy limits, they must pay for all additional medical care costs out of pocket.

¹⁹¹ Someone eligible for employer-sponsored insurance that is deemed unaffordable will also be eligible.

¹⁹² PPACA § 1302(d)(1)(D), 42 U.S.C.A. § 18022(d)(1)(D) (West Supp. 1B 2010).

¹⁹³ This is not completely true to the extent that subsidies are provided for insurance that covers EHBs, which might also advance Health Promotion goals. For a description of EHBs, see *id.* § 1302(b), 42 U.S.C.A. § 18022(b).

¹⁹⁴ PPACA sec. 1001, § 2711, 42 U.S.C.A. § 300gg-11(a) (West Supp. 1A 2010). For the effective date, see *id.* § 1004(a), 42 U.S.C.A. § 300gg-11 note.

¹⁹⁵ PRICEWATERHOUSECOOPERS, THE IMPACT OF LIFETIME LIMITS 1 (2009), *available at* <http://www.hemophilia.org/docs/LifetimeLimitsReport.pdf>.

¹⁹⁶ *Id.*

These types of limits had previously created the potential for significant financial insecurity among a small, very sick population.¹⁹⁷

The lifetime limits apply uniformly to all individual and group health plans, including grandfathered and self-insured plans, and the annual limits apply to all but grandfathered plans. Self-insured plans are a type of ESI where the employer retains the risk for losses.¹⁹⁸ Over half of ESI plans are now self-insured.¹⁹⁹ These plans are exempted from state insurance regulation because of federal preemption under the Employee Retirement Income Security Act of 1974 (ERISA)²⁰⁰ and are also exempted from some of the new PPACA requirements.²⁰¹

Symbolically, the application of these prohibitions to such plans is meaningful. In practice, these rules might be more circumscribed. They apply only to spending on EHBs—the new set of federally mandated benefits discussed above—not to all covered benefits.²⁰² This means, first, that any benefits that are not considered EHBs can still

¹⁹⁷ Again, because this policy is income-blind, it could possibly cushion some costs for people who could afford them. However, medical spending at these levels is likely to create financial insecurity for most American families.

¹⁹⁸ Insurers generally buy reinsurance policies to protect themselves from such risk.

¹⁹⁹ KFF & HRET 2010 SURVEY, *supra* note 175, at 154.

²⁰⁰ See 29 U.S.C. § 1144(b)(2)(B) (2006) (stating that an employee benefits plan may not be “deemed to be an insurance company or other insurer” and thus is exempt from state insurance regulations).

²⁰¹ While there has been some confusion regarding which PPACA regulations apply to self-insured plans, the consensus emerging among regulators and academics is that any regulations that apply to a “group health plan” and do not explicitly exempt self-insured plans apply to them. According to the interim final regulations,

The term ‘group health plan’ is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term ‘health plan,’ as used in other provisions of title I of the Affordable Care Act. The term ‘health plan’ does not include self-insured group health plans.

Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,539 n.1 (June 17, 2010). This means that “group health plan” includes self-insured plans but that “health plan” does not in order to maintain consistency with the other laws that PPACA amends. *Id.* Tim Jost makes a slightly different argument, based on an internal reading of PPACA that is logical only if “group health plan” includes self-insured plans. See Tim Jost, *How Does the Health Reform Legislation Affect Self-Insured Plans?*, LEGAL SOLUTIONS IN HEALTH REF.: AN O’NEILL INST. BLOG (Mar. 31, 2010, 5:24 PM), <http://oneillhealthreform.wordpress.com/2010/03/31/how-does-the-health-reform-legislation-affect-self-insured-plans>. Even with this more inclusive interpretation, several important aspects of the insurance regulations, such as coverage of “essential health benefits” discussed in Section III.A, do not apply to self-insured plans.

²⁰² PPACA secs. 1001(5), 10101, § 2711(b), 42 U.S.C.A. § 300gg-11(b) (West Supp. 1A 2010).

have spending limits. Second, some employers can choose not to cover EHBs to avoid unbounded coverage. Both self-insured plans and grandfathered plans, which make up a majority of private health plans, are not required to cover these EHBs.²⁰³ Even though the categories of EHBs describe services that ESI plans typically have covered,²⁰⁴ self-insured employers could end coverage of certain EHBs if they deemed it too expensive to include such coverage without limits as a backstop on total plan exposure.²⁰⁵ To the extent that self-insuring grows to avoid coverage of EHBs, the restriction on plan limits could directly undermine the goal of the limits, as well as the goal of mandating coverage of EHBs.²⁰⁶ Despite these potential shortcomings in application, the clear intent and the likely outcome of these policies is to reduce financial insecurity from “underinsurance,” particularly for the chronically ill, in the face of catastrophically high costs by requiring health plans to cover and thus distribute any individual’s excessively high medical care costs among all insureds.²⁰⁷

Finally, while not part of the private insurance reforms, the expansion of Medicaid is worth brief mention because increased eligibility for coverage strongly protects against financial exposure. Prior to reform, only certain populations, such as children, parents, and pregnant women who met financial criteria, were eligible for most states’ Medicaid programs.²⁰⁸ This “categorical eligibility” has been lifted so that anyone who earns below 133% of the FPL is now eligible.²⁰⁹ In addition, while, prior to reform, states had significant discretion over how much of the eligible population they would cover, they are, post-

²⁰³ See PPACA § 1302(a), 42 U.S.C.A. § 18022(a) (West Supp. 1B 2010); *see also supra* note 201 (explaining why § 1302(a), applying to “any health plan,” does not include such plans). Coverage of some of these services is required elsewhere in PPACA. For example, self-insured (but not grandfathered) plans must cover preventive services under section 1001. PPACA sec. 1001, § 2713, 42 U.S.C.A. § 300gg-13 (West Supp. 1A 2010) .

²⁰⁴ In fact, PPACA directs the Secretary of HHS to review benefits in employer-sponsored plans to help define “essential health benefits.” *Id.* § 1302(b)(4), 42 U.S.C.A. § 18022(b)(4) (West Supp. 1B 2010).

²⁰⁵ A grandfathered plan would, however, lose its grandfathered status if it made substantial changes to coverage, subjecting it then to the essential health benefits rules. *See* Temp. Treas. Reg. § 54.9815-1251T(g)(1)(i) (2010).

²⁰⁶ *See infra* subsection II.D.2.

²⁰⁷ Again, this conception of financial security does not address either income or assets. It caps exposure for someone who might be able to afford the out-of-pocket costs as well as for someone who might not. Presumably, this overinclusiveness may be more of a conceptual problem, though, since few people could manage costs at these high levels.

²⁰⁸ *See generally Medicaid Eligibility Overview, supra* note 168.

²⁰⁹ PPACA § 2001(a)(1), 42 U.S.C.A. § 1396(a)(10)(A)(i).

reform, required to offer Medicaid to anyone who meets federal eligibility rules—a requirement that in part spurred states' legal challenges to the law.²¹⁰ To preserve access to providers in light of the coverage expansion, PPACA has funded increased Medicaid reimbursements for primary care services²¹¹ and the training of additional primary care physicians.²¹² Thus, the new Medicaid enrollees, to the extent they can access medical care,²¹³ will be able to obtain it with meaningful protection from financial exposure.

In sum, the above policies constitute core elements of health reform aimed at reducing Americans' financial exposure to medical care costs. These policies do not, however, eliminate such exposure. They are circumscribed in large part due to funding constraints, and they define financial insecurity in rigid, bright-line ways. If Financial Security goals were the primary focus of the law, we might see more resources devoted to these policies, both to fund subsidies and to draw more refined definitions of financial security. For example, more money might be allocated to tax credits for premiums and cost sharing so that anyone earning under 400% of the FPL would be eligible, even if her insurance were through an employer rather than a state exchange. Or additional dollars could be spent on Medicaid expansion or enhanced reimbursements for providers participating in the Medicaid program. Or the out-of-pocket limits could be designed on a sliding scale based upon income and assets. But such emphasis on protecting insureds against vulnerability to medical care costs might be partly at

²¹⁰ See generally Sara Rosenbaum, A "Customary and Necessary" Program—Medicaid and Health Care Reform, 362 NEW ENG. J. MED. 1952 (2010) ("Claiming that the law 'converts what had been a voluntary federal-state partnership into a compulsory top-down federal program in which the discretion of [states] is removed,' the lawsuit attempts to portray states as compelled . . ." (alteration in Rosenbaum) (quoting Complaint at 5, State of Florida v. U.S. Dep't of Health & Human Servs., No. 10-0091 (D. Fla. Mar. 23, 2010))).

²¹¹ HCERA sec. 1202(a)(1), § 2303(a)(2), 42 U.S.C.A. § 1396.

²¹² PPACA § 5301, 42 U.S.C.A. § 293k (West Supp. 1A 2010).

²¹³ Some criticize the quality of access available through this coverage because some physicians will not accept the low reimbursement rates under some states' Medicaid programs, as well as because of a general shortage and uneven geographical distribution of primary care physicians. See, e.g., KATHRYN NIX, THE HERITAGE FOUND., WEBMEMO NO. 2873, OBAMACARE: IMPACT ON THE UNINSURED 1 (2010), <http://report.heritage.org/wm2873> (noting that doctors refuse Medicaid patients due to reimbursement concerns); Robert Pear, *Doctor Shortage Proves Obstacle to Obama Goals*, N.Y. TIMES, Apr. 27, 2009, at A1 ("The need for more doctors comes up at almost every Congressional hearing and White House forum on health care."). Massachusetts saw significant access problems with expanded coverage. See MASS. MED. SOC'Y, PHYSICIAN WORKFORCE STUDY 2-3 (2010) (describing physician shortages, particularly in primary care and internal medicine).

the expense of other goals, as explored in Section III.C below. Thus, the law simultaneously adopts significant Financial Security policies and also constrains their reach and the amount of effort necessary to implement them.

C. *Brute Luck*

So, self-responsibility is going to be critical. . . . [E]very business out there is going to be looking at their health care bottom line. And increasingly what you're going to see is that businesses are going to incentivize their employees to stop smoking, lose weight, get exercise, get regular checkups. . . . [T]he American people are going to have to participate in their own health.

President Barack Obama²¹⁴

We can build a health care system that is more responsive to our needs and is delivered to more people at lower cost. The "solution" . . . resides where every important social advance has always resided—with the American people themselves, with well informed American families making practical decisions to address their imperatives for better health and more secure prosperity. The engine of our prosperity and progress has always been our freedom and the sense of responsibility for and control of our own destiny that freedom requires.

Senator John McCain (R, AZ)²¹⁵

This summer, those are the principles that will guide us. And our destination is a country in which no one will ever have coverage denied because of pre-existing conditions . . . a country in which no one will ever again suffer financial disaster because they had the bad luck to get sick.

Congressman Steny Hoyer (D, MD)²¹⁶

1. Theory

The final dominant American conception of health insurance that shaped key PPACA policies, including new insurance-rate regulation and wellness-program discounts, is that insurance should primarily mitigate losses that an insured should not reasonably foresee and fore-

²¹⁴ Nancy Snyderman, *Obama on Health Care Policy: "No Free Lunch,"* MSNBC.COM (July 16, 2009, 9:04:56 A.M.), http://www.msnbc.msn.com/id/31929715/ns/health-health_care.

²¹⁵ John McCain, *Better Care at Lower Cost for Every American*, CONTINGENCIES, Sept.–Oct. 2008, at 28, 31, *available at* <http://www.contingencies.org/septoct08/mccain.pdf>.

²¹⁶ Press Release, Representative Steny Hoyer, Hoyer Gives Remarks on the 43rd Anniversary of Medicare (July 1, 2009), *available at* http://hoyer.house.gov/index.php?option=com_content&task=view&id=1700&Itemid=57.

stall.²¹⁷ This notion of insurance appeals to a sense of personal responsibility that has long informed American public policy.²¹⁸ Michele Landis Dauber has described how “narratives of blame and fate” shaped determinations of who was worthy of disaster relief throughout the nineteenth century.²¹⁹ She further contends that these early disaster-relief narratives informed the rhetoric underlying the New Deal and American welfare state.²²⁰ Beyond the United States, in studies in Belgium, Burkina Faso, Indonesia, and the United Kingdom, a majority of those surveyed expressed a willingness to ration health care with sensitivity to personal responsibility.²²¹

Some advocates of this approach argue that it is most consistent with other forms of liability insurance that carve out coverage of intentional harms or charge policyholders more for negligence or for other risky conditions they create or accept, which increase the likelihood of harm.²²² For example, homeowners’ insurance pays for damages from an accidental fire, but not from one the policyholder sets intentionally. Further, an insurer will charge more for a policy to insure a home that is far from a fire hydrant or made of materials that are more flammable because these conditions increase the risk of fire or the potential extent of losses in the case of a fire. The price of an automobile insurance policy likewise increases after a policyholder is

²¹⁷ See *supra* notes 19-22 and accompanying text (introducing this theory). Note that this theory creates incentives for information acquisition and risk avoidance: if a behavior is considered a health risk, insureds are expected both to know that this behavior is a risk and to avoid it.

²¹⁸ See, e.g., Michele L. Landis, *Fate, Responsibility, and “Natural” Disaster Relief: Narrating the American Welfare State*, 33 L. & SOC’Y REV. 257, 261 (1999) (noting the “idea that there is an entrenched American preference for certain kinds of plights over others” (citations omitted)).

²¹⁹ *Id.* at 260; see also *id.* at 270 (“The need to fit new claims within a set of precedents required successful appeals to describe events in a particular narrative form: sudden, unforeseeable events for which the petitioner was blameless . . .”).

²²⁰ *Id.* at 260.

²²¹ See Nir Eyal, *Deep Exclusionary Reasons: The Case of Luck Egalitarianism and Personal Responsibility for Health* 11 (unpublished manuscript), available at <http://www.law.harvard.edu/programs/petrie-flom/workshop/eyal.pdf> (last visited Mar. 15, 2011) (citing Paul Dolan & Aki Tsuchiya, *The Social Welfare Function and Individual Responsibility: Some Theoretical Issues and Empirical Evidence*, 28 J. HEALTH ECON. 210 (2009), and Erik Schokkaert & Kurt Devooght, *Responsibility-Sensitive Fair Compensation in Different Cultures*, 21 SOC. CHOICE & WELFARE 207 (2003)).

²²² See HOLMES, *supra* note 18, § 116.1 (stating that the “implied exception” insurance doctrine withholds coverage where an insured intentionally causes or expects harm); Mariner, *supra* note 7, at 445 (explaining that the “known loss doctrine precludes coverage of a loss that has already occurred or that the policyholder reasonably expected to occur”).

found at fault in an accident. Life insurance often carves out death by suicide for an initial period or charges someone in poor health higher premiums.²²³ Directors' and officers' insurance that indemnifies harms caused by a board member sometimes carves out harms resulting from willful or fraudulent acts or gross negligence.²²⁴

Likewise, health insurance could differentiate losses that an insured should reasonably avoid (choice) from those the insured should, or could, not (chance).²²⁵ The idea is that health insurance would isolate and redistribute the costs of misfortune, or what Ronald Dworkin calls "brute luck." He distinguishes "brute luck" from "option luck," by explaining:

Option luck is a matter of how deliberate and calculated gambles turn out—whether someone gains or loses through accepting an isolated risk he or she should have anticipated and might have declined. Brute luck is a matter of how risks fall out that are not in that sense deliberate gambles.²²⁶

For example, initial genetic makeup—including any flaws or gifts—is generally considered a result of an individual's brute luck. In contrast, winning the lottery, losing money on a failed business venture, or breaking a leg on a skydiving adventure gone awry are the result of option luck. Abraham argued that someone agrees to risk of loss when *choosing* to engage in a high-risk activity.²²⁷

Both egalitarian and efficiency arguments are made for prioritizing allocation of insurance dollars based upon avoidability of harm.

²²³ See Gary Schuman, *Suicide and the Life Insurance Contract: Was the Insured Sane or Insane? That is the Question—Or Is It?*, 28 TORT & INS. L.J. 745, 745-46 (1993) (noting that life and accident policies "almost always include a provision that if the insured commits suicide within a period of time specified in the policy, then the insurer shall not be obligated beyond returning the premiums paid" (footnote omitted)).

²²⁴ See Michael Sean Quinn & Andrea D. Levin, *Directors' and Officers' Liability Insurance: Probable Direction in Texas Law*, 20 REV. LITIG. 381, 433-34 (2001) (discussing directors' and officers' insurance policy exclusions for "fraud, dishonesty, and deliberate criminality").

²²⁵ This standard implies that we expect insureds to *understand* certain risks and know that they should mitigate them. This expectation may be too high for some health risks, in which case policies could be designed to cover such risks.

²²⁶ RONALD DWORKIN, *SOVEREIGN VIRTUE* 73 (2000). *But see* Peter Vallentyne, *Brute Luck, Option Luck, and Equality of Initial Opportunities*, 112 ETHICS 529, 532-38 (2002) (arguing that brute luck might be easier to define in theory than in application). Avoidability is difficult to determine because it relies upon an account of what is reasonably avoidable, which could be difficult or meaningless to distinguish in close cases, and arbitrary if people are not fully informed, rational decisionmakers. *See id.* at 533 (noting, for example, that "[l]ying on the ground may sometimes be reasonable, but it is certainly unreasonable in many contexts").

²²⁷ *See* ABRAHAM, *supra* note 19, at 28-29 (noting the "effort to assure the affordability of insurance for socially unavoidable activities" as opposed to "optional pursuits").

Some egalitarians argue for a model of distributive justice based on differential treatment of avoidable and unavoidable harms. These luck-egalitarian philosophers have argued that inequities that result from brute luck should be neutralized to create greater equality.²²⁸ The idea is that it is *unjust* to ask the ill and injured to pay the costs of unavoidable conditions that impair their welfare.²²⁹ Consider a man with a congenital heart defect. While imposing higher premiums or cost-sharing obligations on him better reflects the costs he is likely to impose on the insurance pool, a luck egalitarian would consider doing so morally unjust. Insurance coverage that pays for care for the man's heart defect can neutralize the random disadvantage he faces if he would otherwise pay for his own medical care or if his condition would go untreated. To be clear, insurance coverage for his condition under

²²⁸ See, e.g., DWORKIN, *supra* note 226, at 73-74 (distinguishing between "deliberate gambles" and "brute bad luck"); Richard J. Arneson, *Equality and Equal Opportunity for Welfare*, 56 PHIL. STUD. 77, 85-87 (1989) (exploring the theory of "equal opportunity for welfare," wherein differences in life outcomes are due not to social inequities but rather to individual decisionmaking); G.A. Cohen, *On the Currency of Egalitarian Justice*, 99 ETHICS 906, 916 (1989) (proposing an "equal access advantage" theory, wherein involuntary disadvantages—those beyond the actor's control—merit compensation, while disadvantages incurred voluntarily by the actor do not). Other luck-egalitarian discussions offer amendments to this bright-line rule. See generally SHLOMI SEGALL, HEALTH, LUCK, AND JUSTICE 45-110 (2010) (discussing various luck-egalitarian approaches and applications to health care concerns); Eyal, *supra* note 221, at 16 ("At some level we all grasp that, strictly in distributive justice terms, there is no objection to denying reckless risk takers related benefits, including medical benefits; but we also sense strong reasons . . . to behave, communicate and even believe that distributive justice opposes their abandonment."); Shlomi Segall, *In Solidarity with the Imprudent: A Defense of Luck Egalitarianism*, 33 SOC. THEORY & PRAC. 177, 198 (2007) (noting that "the principle of solidarity retains the distinction between the responsible and the irresponsible, allowing for (independent) penalties for irresponsible, and unnecessarily risky, conduct"); Vallentyne, *supra* note 226, at 531, 537-38, 543-44 (arguing that brute luck is a difficult concept to define, that the line between brute and option luck is tenuous, and that in some cases, neutralizing brute luck is inefficient and thus undesirable).

Daniel Markovits has suggested ways to amend this baseline rule. See generally Daniel Markovits, *How Much Redistribution Should There Be?*, 112 YALE L.J. 2291, 2298-99 (2003) (contending that "responsibility-tracking" egalitarianism that attempts to distinguish brute and option luck is problematic); Daniel Markovits, *Luck Egalitarianism and Political Solidarity*, 9 THEORETICAL INQUIRIES L. 271, 275-76 (2007) (agreeing with criticisms of the "responsibility-tracking" strand of luck egalitarianism and supporting "more modest luck egalitarianism"). But cf. Elizabeth S. Anderson, *What is the Point of Equality?*, 109 ETHICS 287, 288-89 (1999) (criticizing certain egalitarians for their preoccupation with brute luck concerns and arguing instead that the focus of egalitarianism should be eliminating societal oppression); Wikler, *supra* note 102, at 47 (arguing that "personal responsibility for health deserves but a peripheral role in health policy").

²²⁹ See ABRAHAM, *supra* note 19, at 29 (arguing that treating individuals as equals "requires that we all bear certain risks beyond some individuals' control even though this risk sharing may increase the costs of some activities").

a Brute Luck theory might not guarantee him equal results to those of someone born without such a condition; he may never be as healthy as someone born without the defect. But to the extent possible through medical interventions (subject to allocation decisions discussed below), insurance spreads the costs of this man's defect among those who enjoyed the fortune of good health at birth.

In addition to neutralizing random initial allocations of health, Brute Luck insurance would also indemnify unavoidable harms suffered over an insured's lifetime.²³⁰ Insurance might cover, for example, medical care costs resulting from childhood leukemia, hereditary breast cancer, or injuries from a random, unpreventable accident to the extent that these harms are out of the insured's control. Conversely, insurance would not cover harms resulting from an insured's own acts or choices, such as the costs of setting a broken leg from a rock climbing accident. Likewise, while a less clear and perhaps more controversial policy, insurance might not cover costs of routine childbirth to the extent that such costs are incurred as a result of a choice to procreate.²³¹ In other words, maternity care services that health insurance coverage has commonly included and that some states have even mandated²³² might not be covered under Brute Luck insurance.

Others favor this model of insurance for its ability to preserve incentives for personal responsibility for healthy behaviors. Brute Luck insurance creates incentives for individuals to avoid poor health where efficient and possible, while providing a cushion for losses that occur despite such preventive investments. In doing so, this model—if well executed—facilitates efficiency in the insurance market. According to Kenneth Abraham, drawing from Guido Calabresi's *Cost of Accidents*,

²³⁰ Dworkin, for example, might support this sort of policy. See DWORKIN, *supra* note 226, at 73-74 ("If someone develops cancer in the course of a normal life, and there is no particular decision to which we can point as a gamble risking the disease, then we will say that he has suffered brute bad luck."). But Vallentyne would support such equalization only if efficient. See Vallentyne, *supra* note 226, at 543 ("[J]ustice requires compensation for brute outcome luck when and only when doing so is a way of increasing the value of people's initial opportunities.").

²³¹ If not paying for such care would result in brute-luck harm to the newborn, insurance might still pay for the care to mitigate such harm or, if not, might at least pay for medical care for the infant.

²³² Eighteen states have mandated that insurers provide coverage for maternity care in some form. See The Henry J. Kaiser Family Found., *Mandated Coverage of Maternity Care, January 2010*, STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparetable.jsp?ind=687&cat=7> (tracking coverage of maternity care by state). PPACA includes maternity and newborn care as one of the enumerated categories of "essential health benefits." PPACA § 1302, 42 U.S.C.A. § 18022 (West Supp. 1B 2010).

“Insurance law promotes efficiency whenever it is structured to help reduce the sum of the costs of insurance and loss prevention. The intuitive idea behind this formula is that resources are allocated inefficiently whenever more could be saved through loss prevention than can be protected through insurance.”²³³ In the case of health insurance, for example, if insurance were to fully compensate knee replacement surgery following destruction of the joint, an extreme-sports enthusiast might have less motivation to consider moderation. However, if she knew (or should have known) that she would have to live to an old age with any joint damage she created in her youth, or pay for expensive surgery on her own, she might be more likely to engage in physical therapy to stabilize and support her joints, to take nutritional supplements for joint health, or to take a day or two off.²³⁴ In contrast, there would be no deterrence benefit to requiring the man who was born with a heart defect to pay for the significant medical care necessary over his lifetime.²³⁵ Charging him more for insurance to reflect his high expected costs does little to deter future medical care costs of this type, since initial bad luck made them necessary.²³⁶ Such considerations have been taken up by “personal responsibility” advocates, who argue for insurance design that creates incentives for insureds to take responsibility for their own health with one end goal being a reduction in medical care spending.²³⁷ Thus, what I call the Brute Luck theory of health insurance captures both of these intuitions and stands for the idea that insurance should prioritize coverage of medical expenses for harms that the insured should not reasonably foresee and forestall.

²³³ ABRAHAM, *supra* note 19, at 11 (footnote omitted); *see also* GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* 26 (1970) (“Apart from the requirements of justice, I take it as axiomatic that the principal function of accident law is to reduce the sum of the costs of accidents and the costs of avoiding accidents.”).

²³⁴ This idea assumes that people are better informed about their health insurance coverage than they probably are, and it would therefore have to be accompanied with insurance-education campaigns to be effective.

²³⁵ One might contend it is efficient, nonetheless, to require him to internalize the costs he will generate.

²³⁶ There could also be a distinction based on the degree to which maternal behavior caused the birth defect and whether imposing such costs could deter future harm to fetuses. On the flip side, however, we could envision undesirable cost-avoidance implications of the Brute Luck theory, such as selective abortion of fetuses with disabilities.

²³⁷ *See, e.g.*, REGINA E. HERZLINGER, *MARKET-DRIVEN HEALTH CARE* 245-52 (1997) (advocating for consumer-driven health care and arguing that such a change would cause health care costs to drop); Pauly, *supra* note 19, at 534 (noting that while individuals may recognize that excessive use of medical care contributes to higher total premiums, incentive misalignment eliminates individuals’ incentives to curtail their own use).

But relying on a distinction between choice and chance to shape the design of health insurance is extremely complex, both normatively and operationally. As is the case with the two prior models, proponents of the Brute Luck model might disagree on the details of how to translate this concept into insurance design. First, even some who support a Brute Luck approach would temper its application in some circumstances.²³⁸ In a recent article, Nir Eyal discusses the “harshness objection” that Elizabeth Anderson and others have raised to a theory of justice that requires denying medical care for certain avoidable harms.²³⁹ Eyal recounts the example of a reckless driver who hits a tree and will be seriously disabled unless “immediately evacuated to [a] hospital.”²⁴⁰ While the driver’s injuries result from his own reckless driving, many would have the intuition to rescue him nonetheless.²⁴¹ Eyal examines exceptions that “luck-egalitarian pluralists” have proposed to the personal-responsibility rule to overcome this objection.²⁴² The theory of Brute Luck insurance, discussed herein, deviates somewhat from the reckless driver example because the theory concerns rationing of payment for care, not rationing of care itself. Even if ethical considerations demand saving the driver, perhaps insurance still should not cover his airlift and medical care costs—the costs of his reckless driving. Arguably, he is less entitled to use dollars from a shared health insurance pool to pay for his care. Some might still advance a harshness objection to limited funding for his care; others might not. The relevant point for the present discussion is that even those who support personal responsibility as an allocation prin-

²³⁸ See, e.g., Eyal, *supra* note 221 (exploring various accounts of pluralist luck egalitarianism in the health context and explaining why proponents of these theories might still “rescue” people who have caused their own poor health).

²³⁹ See *id.* at 1-2.

²⁴⁰ *Id.* at 1.

²⁴¹ *Id.* at 15.

²⁴² See *id.* at 2-14. For example, personal responsibility might work better as one factor among many, as Shlomi Segall advocates. See *id.* at 3-4 (arguing that the fulfillment of people’s basic needs “overrides” distributive justice concerns within luck egalitarianism and therefore demands that the “prudent” and “imprudent” be treated equally (quoting SEGALL, *supra* note 228, at 76-77) (internal quotation marks omitted)); see also Segall, *supra* note 228, at 194-98 (contending that people who could have avoided harms may still merit protection due to the “principle of solidarity” that requires “collective responsibility” for “certain losses incurred by individual members”). Alternatively, avoidability might be useful if applied only as a second-order consideration, after first-order considerations of, for example, enabling democratic participation. See Eyal, *supra* note 221, at 6-8. Eyal further considers additional exceptions in broadening the scope that all but swallow the personal responsibility rule. *Id.* at 8-14.

ciple for funding medical care disagree on its applicability in cases where the result is arguably harsh.

Second, advocates of this theory likely hold different conceptions of what is choice and what is chance and how to array harms on a scale from avoidable to random. It is difficult to discern the degree of choice in a particular act. To do so, it is necessary to determine if the insured had reason to know what would cause a harm (i.e., she knew how to prevent it), if she was in control of any triggers (i.e., she could have prevented it), and if she opted to pull those triggers (i.e., she chose not to prevent it). These determinations are especially complex with respect to medical harms.²⁴³ When dealing with illness or injury, it is often unclear what causes a particular illness or injury. Medical causation is often difficult to prove, is underresearched, and is multifaceted.²⁴⁴

In addition, in many cases, it is debatable whether the root cause of a harm, once identifiable, is within an insured's control (and to what degree) and whether she knew (or should have known) that she was assuming a risk she could prevent. Some would argue that all actions reflect freely made choices; thus, we should look narrowly at individuals' behavior to determine their choices.²⁴⁵ This approach dominates much of neoclassical economics research, where individuals are considered—at the core—rational actors whose acts reflect their choices. At the other extreme, others believe many choices are constrained by factors such as biology, psychology, or social environment.²⁴⁶ Consider, for example, a man who works on an oil rig because it is the only job he can get that enables him to make ends meet. If he faces back strain and arthritis later in life because of the intense physical nature of his oil rig work, some would say these harms are the result of his free choice to take a taxing job for higher income, and others would

²⁴³ See Wikler, *supra* note 102, at 49-52 (identifying numerous external factors, such as the influence of role models or poverty, that complicate the question of whether certain unhealthy behaviors are actually within an individual's "control").

²⁴⁴ For articles discussing the complexity of medical causation, see, for example, D.I.W. Coggon & C.N. Martyn, *Time and Chance: The Stochastic Nature of Disease Causation*, 365 LANCET 1434 (2005); A.J. McMichael, Commentary, *Prisoners of the Proximate: Loosening the Constraints on Epidemiology in an Age of Change*, 149 AM. J. EPIDEMIOLOGY 887 (1999).

²⁴⁵ This is the approach used to define "preferences" in rational-choice theory. See generally GARY S. BECKER, *THE ECONOMIC APPROACH TO HUMAN BEHAVIOR* (1976).

²⁴⁶ See generally Frederick J. Zimmerman, *Structure, Agency, and Institutions: A Multi-Level Theory of the Determinants of Population Health* (Dec. 22, 2010) (unpublished manuscript) (on file with author) (criticizing simplistic accounting of preferences and proposing a more complex model for understanding human choices); see also *supra* note 102 (discussing social determinants of health).

say his choices were constrained by his lot in life. Some examples are even murkier. Studies by public health scholars have also suggested that certain unhealthy *behaviors* are due in part to genetics or socioeconomic status.²⁴⁷ For example, someone who has experienced low socioeconomic status in her lifetime is statistically more likely to smoke cigarettes and eat unhealthy foods.²⁴⁸ For some, obesity is a choice. However, studies of genetics and environment suggest that, for others, it may be more difficult or impossible to avoid obesity even if they desire to be otherwise.²⁴⁹ Thus, harms do not always fall clearly into categories of choice and chance, but rather array along some debatable spectrum of grays. The translation of Brute Luck theory into insurance design differs depending on how lines are drawn between choice and chance. What unites supporters of this approach, regardless of where they might draw lines, is the idea that lines should be drawn along the dichotomy of chance harms versus choice harms.

Translating this idea into practice, coverage would be more comprehensive for harms deemed the result of chance and less for those deemed the result of choice, and impliedly reasonably avoidable. Insurers could charge higher premiums to anyone who unreasonably assumed health risks through their actions or inaction. Cost-sharing obligations for medical care would vary based on the degree of the insured's complicity in a medical harm. Insurance policies could completely carve out coverage for negligently incurred health care costs, although doing so might be met with harshness objections. For example, if someone suffers from a disease that was unavoidable, her cost-sharing obligations at the time of treatment would be little to none. However, if she were genetically predisposed to back pain and

²⁴⁷ See Pearce & Smith, *supra* note 102, at 125 (noting the idea that health is related to social factors because of "the influence of social cohesion on health-related behaviors"); see also S.A. Reijneveld, *The Impact of Individual and Area Characteristics on Urban Socioeconomic Differences in Health and Smoking*, 27 INT'L J. EPIDEMIOLOGY 33, 35, 38 (1998) (finding that poor health behaviors in impoverished areas are due overwhelmingly to individuals' low socioeconomic status).

²⁴⁸ See J.W. Lynch et al., *Why Do Poor People Behave Poorly? Variation in Adult Health Behaviours and Psychosocial Characteristics by Stages of the Socioeconomic Lifecourse*, 44 SOC. SCI. MED. 809, 809 (1997) ("The existence of socioeconomic inequalities in health has been well established. Attempts to explain these inequalities have often made reference to the fact that behavioural factors, such as smoking, physical activity, and diet, are differentially distributed by socioeconomic levels.").

²⁴⁹ See, e.g., Claude Bouchard, *Genetics of Obesity: Overview and Research Directions* ("The limited molecular marker studies published so far suggest that there will likely be several genes associated and/or linked with human obesity."), in *THE GENETICS OF OBESITY* (Claude Bouchard ed., 1994). For more information on this topic, see generally the collection of essays in *THE GENETICS OF OBESITY*, *supra*.

then also acted in a way likely to trigger onset of the pain (knowing that her actions might do so), she would incur cost-sharing obligations corresponding to her level of complicity in the onset of the pain.²⁵⁰ If, in contrast, she had no genetic predisposition to back pain and induced it fully and knowingly through actions of her choice, she would be subject to high or total cost sharing. If an insurance company were to gauge all nonrandom risk and incorporate it into pricing, the only risks that would remain for redistribution would be those that are unpreventable or unforeseeable.²⁵¹

Individual assumption of risk has, for some time, factored into private insurance design and actuarial risk-rating rules, especially in the individual market.²⁵² Actuarial risk rating reflects consideration of two types of risks, one type that is consistent with a Brute Luck approach and one that is not. On the first, insurers have charged more for insurance if an applicant's behaviors or lifestyle choices make her more likely—as determined by the insurance company—to incur high medical care costs.²⁵³ Insurers have long required people who participate in high-risk occupations or hobbies or who drink or smoke to pay higher insurance premiums or cost-sharing obligations.²⁵⁴ Conversely, and also consistent with a Brute Luck understanding of insurance, antidiscrimination laws have prohibited premium variation based on certain factors that are more random, such as genetic makeup and

²⁵⁰ For a philosophical discussion of different ways one might determine how to attribute particular bad outcomes to individual action and to what degree, see generally, for example, Arneson, *supra* note 228.

²⁵¹ See ABRAHAM, *supra* note 19, at 2 ("When such pricing is accurate, there is considerable individual risk bearing, for then the insured pays a premium based on the predictable risk that he or she will suffer a loss. The insurer simply pools the risk of unpredictable individual losses.").

²⁵² See Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517, 517, 534-35 (1983) (examining how an individual's occupation and geographic location are among factors that affect her "riskiness" grouping in insurance markets); Light, *supra* note 42, at 2503-04 (describing direct and indirect risk rating); see also Jonathan Simon, *The Ideological Effects of Actuarial Practices*, 22 LAW & SOC'Y REV. 771, 771-73 (1988) (describing the ubiquity of actuarial techniques in modern day society and how they are used in industries, like the insurance market, to allocate risk).

²⁵³ Many of the presumed risky factors that have been used over time do not statistically predict high medical care costs; bias, more than evidence, might drive such factors. See Robert Works, *Whatever's FAIR—Adequacy, Equity, and the Underwriting Prerogative in Property Insurance Markets*, 56 NEB. L. REV. 445, 471 (1977) ("Although the core concern of the underwriter is the human characteristics of the risk, cheap screening indicators are adopted as surrogates for solid information . . . The invitations to underwriters to introduce prejudgments and biases . . . are apparent."), *quoted in* Austin, *supra*, note 252, at 534 n.92.

²⁵⁴ Light, *supra* note 42, at 2503.

race.²⁵⁵ Prohibiting the use of such criteria, which might accurately predict individual risk, sacrifices a degree of actuarial accuracy and economic efficiency to avoid what have been deemed undesirable, discriminatory practices.

Other practices are less consistent with Brute Luck notions. Insurers in many states also consider preexisting conditions, which may or may not have been avoidable themselves, when setting insurance premium rates. Insurers routinely deny coverage to any applicant considered high risk, regardless of the reason for the perceived risk and whether it was in the insured's control or not.²⁵⁶

In sum, in a Brute Luck insurance regime, rationing and pricing decisions would primarily turn upon difficult determinations of whether the cause of a harm was the result of choice or chance; this approach has been an influence on private markets for some time, despite its complexity and controversial nature, and will continue in modified form under PPACA policies.

2. Brute Luck Policies of PPACA

Even as the Brute Luck conception of health insurance is one that some adamantly defend as "real" insurance, its adoption as an organizing principle for health insurance faces periods of waxing and waning popularity. A Brute Luck notion of insurance underlies several prominent PPACA policies. It is not, however, represented as strongly in PPACA's policies as the first two theories of insurance. This is perhaps unsurprising in light of PPACA's goal of increasing insurance coverage. The first two notions of insurance both feed this expansionary dynamic, by providing support for extending coverage to services that improve health or that protect wealth. The Brute Luck theory, how-

²⁵⁵ See Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, § 101, 122 Stat 881, 883-88 (codified at 29 U.S.C. § 1182 (2006 & Supp. III 2009)) (banning the use of genetic information when setting insurance rates for group health plans).

²⁵⁶ See, e.g., COLLINS ET AL., *supra* note 45, at 3-4 (noting the difficulty of finding affordable coverage for those with preexisting conditions); Melinda Beeuwkes Buntin et al., *The Role of the Individual Health Insurance Market and Prospects for Change*, HEALTH AFF., Nov.-Dec. 2004, at 79, 81 (2004) (describing insurance underwriting as a method of controlling against adverse selection); MICHELLE M. DOTY ET AL., THE COMMONWEALTH FUND, ISSUE BRIEF, PUB. NO. 1300, FAILURE TO PROTECT: WHY THE INDIVIDUAL INSURANCE MARKET IS NOT A VIABLE OPTION FOR MOST U.S. FAMILIES 1-3 (2009), available at <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Jul/Failure-to-Protect.aspx> (noting the difficulty of finding affordable coverage in the individual market); Katherine Swartz, *Justifying Government as the Backstop in Health Insurance Markets*, 2 YALE J. HEALTH POL'Y L. & ETHICS 89, 97 (2001) (discussing methods by which insurers can distinguish high-risk individuals from low-risk individuals).

ever, could be seen to advocate contraction of coverage to a more limited set of chance risks. While it would not necessarily be inconsistent to expand coverage to more people and simultaneously to limit the scope of that coverage, PPACA does not do so. Over time, however, the expansionary nature of PPACA's policies may prove too expensive to sustain. Thus, Brute Luck principles might grow in importance if goals of cost control trump those of coverage expansion.

Despite its less ubiquitous presence, Brute Luck theories of insurance are represented in several important PPACA policies regarding pricing of insurance and scope of coverage. PPACA changed the rules for premium pricing in several ways that could be understood according to Brute Luck justifications. First of all, the legislation prohibits insurers from issuing or pricing insurance based on factors that could result in charging those with bad brute luck higher premiums, limiting consideration to factors that are arguably better—even if imperfect—proxies for isolating bad option luck. For example, one of the most popular policies of PPACA is the prohibition of excluding coverage based on a preexisting condition and of the consideration of a preexisting condition in pricing insurance premiums.²⁵⁷ As mentioned above, consideration of preexisting conditions in issuing, designing, and pricing insurance has conflated illness and injury that were avoidable with illness and injury that were not, excluding individuals from coverage or charging them more regardless of the reason for a preexisting condition. Although this PPACA policy is over-inclusive from a Brute Luck perspective—carving out consideration of all conditions, even if the individual has contributed to their onset—this policy ensures that private insurance will indemnify those who suffer from unavoidable poor health, in line with luck-egalitarian visions of justice. The following two policies counterbalance this overinclusiveness by sanctioning alternate, more precise ways for insurers to identify and charge more for assumed risk.

Post-PPACA, insurers may still differentially charge insureds based on several factors. Now, though, premiums may vary based on only family size, age, geography, and tobacco-use status.²⁵⁸ Two of these factors—tobacco-use status and geography—could both be seen as proxies for the fact that an insured has assumed higher medical care costs than her otherwise similarly situated peers, depending on the degree of choice attributed to decisions about whether to smoke and

²⁵⁷ See PPACA sec. 1201, § 2704, 42 U.S.C.A. § 300gg-3 (West Supp. 1A 2010).

²⁵⁸ *Id.*, § 2701(a)(1)(A), 42 U.S.C.A. § 300gg(a)(1)(A).

where to live. PPACA authorizes insurers to charge smokers premiums 1.5 times greater than those for nonsmokers.²⁵⁹ Studies show that smokers' medical care costs are as much as 40% higher than nonsmokers' expenses.²⁶⁰ Charging smokers more for premiums can be seen as a tax on risk assumption, creating incentives to quit (i.e., risk avoidance) by charging more for a high-risk behavior.²⁶¹ A Brute Luck theory could also justify geography-based premium adjustments—although perhaps choice is less evident in this instance. Per-person medical care expenses in the United States, adjusted for the health, age, sex, and race of the population, vary geographically by more than a factor of almost three to one from high-cost to low-cost medical regions.²⁶² Sometimes, high- and low-cost medical care regions are quite similar in many regards.²⁶³ To the extent someone assumes the risk of high medical care costs by choosing to live and receive care in a high-cost area, presuming she could choose otherwise, a Brute Luck policy to charge more for coverage would serve to deter avoidable use of health care in high-cost areas.²⁶⁴

Perhaps more monumentally, the legislation expands the scope of discounts that employers and insurers can offer subscribers for participation in wellness programs where they can, presumably, reduce the

²⁵⁹ *Id.* § 2701(a)(1)(A)(iv), 42 U.S.C.A. § 300gg(a)(1)(A)(iv).

²⁶⁰ See Jan J. Barendregt et al., *The Health Care Costs of Smoking*, 337 NEW ENG. J. MED. 1052, 1053 (1997) ("The difference varies with the age group, but among 65-to-74-year-olds the costs for smokers are as much as 40 percent higher among men and as much as 25 percent higher among women.").

²⁶¹ This policy, of course, presumes that smoking is a choice. To the degree tobacco smoking is much more likely for someone who is born into a poor, inner-city household or who has a genetic predisposition for addiction, smoking could be a result of brute-luck factors as well as choice. See *supra* note 248 and accompanying text.

²⁶² See Elliott S. Fisher et al., *Slowing the Growth of Health Care Costs—Lessons from Regional Variation*, 360 NEW ENG. J. MED. 849, 850 fig. (2009) (illustrating graphically that per capita 2006 Medicare expenditures in Miami, Florida were approximately \$16,000 compared to approximately \$6000 in Salem, Oregon).

²⁶³ See Atul Gawande, *The Cost Conundrum*, NEW YORKER, June 1, 2009, at 36, 36-37 (comparing health care expenditures in McAllen and El Paso, two similar Texas communities with a wide gap in dollars spent per Medicare enrollee).

²⁶⁴ Again, to the extent people are not aware (and, as a policy matter, should not become aware) that they are moving to a high-cost health region, charging them more for insurance based on geography might not make Brute Luck sense. Likewise, if a decision to move to such a region is not reasonably avoidable, such a policy would be undesirable. If, for example, lower income workers live in expensive health care regions because those areas are also areas with greater employment opportunities, the decision on where to live may be constrained. In such a situation, higher pricing does not serve Brute Luck deterrence and justice aims, even if it causes insureds to internalize the higher costs of care in those regions.

risk of their future medical care costs.²⁶⁵ A wellness program is defined as a program that is “designed to promote health or prevent disease.”²⁶⁶ These programs have historically been allowed as part of group health plans, but they have been heavily regulated to avoid conflict with the nondiscrimination rules under HIPAA.²⁶⁷ PPACA incorporates and expands the two types of wellness programs permitted under HIPAA for group markets and creates a ten-state demonstration project for creation of such programs in the individual market.²⁶⁸ The first type of wellness program provides benefits simply for participation, such as subsidized gym memberships or reduced copayments for participation in smoking-cessation programs, regardless of the outcomes resulting from participation.²⁶⁹ The second type of program provides benefits for attainment of goals and must meet the following conditions: (1) the reward is not over thirty percent of the cost of coverage under the plan; (2) the program is not “a subterfuge for discriminating based on a health status factor”; (3) there is annual opportunity for participation; and (4) the reward is available “to all similarly situated individuals,” which includes providing an alternative standard if it is “unreasonably difficult” or unadvisable for an insured, because of a medical condition, to satisfy the standard.²⁷⁰

Although some argue that wellness discounts are tantamount to allowing price discrimination on the basis of individual health status, if they are well-targeted, these discounts are a more nuanced approach than prior crude risk-rating methods, and they will result in higher charges for assumed risk of poor health, rather than simply for the exis-

²⁶⁵ Such programs represent an area of overlap between goals of the Health Promotion and Brute Luck theories. They hold the potential both to improve health and to create incentives for individuals to prevent health risks responsibly.

²⁶⁶ PPACA § 1201, § 2705(j)(1)(A), 42 U.S.C.A. § 300gg-4(j)(1)(A) (West Supp. 1A 2010).

²⁶⁷ See Michelle M. Mello & Meredith B. Rosenthal, *Wellness Programs and Lifestyle Discrimination—The Legal Limits*, 359 NEW ENG. J. MED. 192, 193 (2008) (noting that HIPAA makes it more difficult for plans to reward attainment of goals than to reward participation); cf. Robert Steinbrook, *Imposing Personal Responsibility for Health*, 355 NEW ENG. J. MED. 753, 754-56 (2006) (describing West Virginia’s Medicaid experiment with a program similar to a wellness program). For more information on the nondiscrimination requirements, see *supra* note 39 and accompanying text.

²⁶⁸ PPACA sec. 1201, § 2705(l), 42 U.S.C.A. § 300gg-4(l).

²⁶⁹ See *id.*, § 2705(j)(1), 42 U.S.C.A. § 300gg-4(j)(1) (distinguishing between wellness programs that are and are not “based on an individual’s satisfying a standard that is related to a health status factor”).

²⁷⁰ *Id.*, § 2705(j)(3), 42 U.S.C.A. § 300gg-4(j)(3).

tence of poor health.²⁷¹ Wellness programs, while arguably imperfect, better isolate and provide discounts to people who actively minimize their future potential losses and charge more to those who do not, to the degree that participation in such programs does indeed reduce health risks. In theory, such a program could serve both deterrence and luck-egalitarian aims. The programs create incentives for insureds to improve their health, to the extent it is medically possible and advisable, and then they charge more to those who do not engage in such risk avoidance.²⁷²

Of course, the nuances of program design can either foster or undercut the ability of the programs to serve these aims. For example, PPACA provides an alternate standard for those who cannot participate for medical reasons—a standard which might be overly broad from a Brute Luck perspective if the medical condition posing the impediment to participation was self-induced.²⁷³ Further, PPACA does not consider other impediments to participation, such as lack of access to physicians and fitness centers, which may themselves result from factors that could be considered bad brute luck.²⁷⁴ Regardless of

²⁷¹ Critics argue that offering participants discounted premiums for goal attainment is an unfair means of cost-shifting to other, presumably less healthy, individuals in the pool who do not attain the wellness-program goals. See generally Harald Schmidt et al., *Carrots, Sticks, and Health Care Reform—Problems with Wellness Incentives*, 362 NEW ENG. J. MED. e3 (2009), <http://www.nejm.org/doi/pdf/10.1056/NEJMp0911552> (discussing concerns related to these incentives that “[i]n some cases . . . are really sticks dressed up as carrots”). For example, if one member receives a premium discount for attainment of lowered cholesterol levels, the insurer must recoup the premium dollars lost in this discount, presuming the member does not offset the discount with reduced medical expenses. One way to “recoup” these dollars is to shift the costs to those who do not participate in wellness programs or fail to achieve goals. The programs could be seen as a back-door way to continue to charge people based upon their relative health status if poor health status prevents achievement of goals. See *id.* at e3(2)-(3).

²⁷² These programs may not reduce the total losses in a risk pool. As noted above, prevention of disease might merely serve to delay, not eliminate, major health expenses. See *supra* note 82 and accompanying text.

²⁷³ Extreme obesity, which may thwart participation, could result from choice or genetics. In defining whether obesity is a disability, some courts have tried to differentiate between “physiologically” caused obesity and, presumably, behavioral obesity, but drawing such lines is difficult at best. For discussion of the treatment of obesity in state and federal antidiscrimination law, see Mello & Rosenthal, *supra* note 267, at 195-96. Mello and Rosenthal also discuss the case, *EEOC v. Watkins Motor Lines, Inc.*, 463 F.3d 436, 443 (6th Cir. 2006), that made the “physiological” distinction. Mello & Rosenthal, *supra* note 267, at 196.

²⁷⁴ If some people are unable or less likely to participate in these programs because of factors beyond their control, the programs harm those whose participation is thwarted by factors some would consider brute bad luck. For example, in German wellness programs, nonparticipants tend to be lower-income insureds, whom evidence

the soundness of the particular policy design, the underlying goal is to provide discounts for those who engage in programs that reduce health risks, consistent with Brute Luck notions.

Finally, the Brute Luck theory emerges in more subtle ways as well. For example, the above-mentioned premium assistance for those earning between 100% and 400% of the FPL provides less financial protection for tobacco smokers, presumably not subsidizing the increased medical costs of smoking.²⁷⁵ As discussed above, subsidies are based on the amount by which the silver level plan premium exceeds an individual's required contribution to premiums, based upon income level.²⁷⁶ The silver level plan premium used for subsidy calculations is adjusted based on what an insurer will charge someone of the insured's age in the insured's geography, but the amount is not adjusted for increased premiums because of the insured's tobacco use or participation in a wellness program.²⁷⁷ This means that the actual premium a smoker pays might be higher than the premium used for the subsidy calculation, which implies that her contribution toward premiums could be considerably more than a similarly situated nonsmoker.

To make this example concrete, as Table 1 below illustrates, if an individual earns \$27,075 a year, or 250% of the FPL,²⁷⁸ PPACA requires she pay 8.05% of her income toward premium costs (\$2180 per year).²⁷⁹ Imagine the second lowest cost individual silver level plan in her state for someone her age costs \$5000 per year. If she smokes, an insurer can charge her 1.5 times the standard premium, or \$7500 per year for

has shown to be less able and less likely to participate because they have neither the time nor the access to physicians and facilities necessary. Participation rates among people in the top socioeconomic quintile are nearly twice those in the lowest. Schmidt et al., *supra* note 271, at e3(2). To the degree someone deems poverty a misfortune, rather than a choice, charging the poor more for insurance for failure to participate would be inconsistent with Brute Luck aims.

²⁷⁵ See PPACA sec. 1201, § 2701(a)(1)(A)(iv), 42 U.S.C.A. § 300gg(a)(1)(A)(iv) (providing that premiums can be increased 1.5 times for tobacco use); *id.* § 1401(a), 26 U.S.C.A. § 36B(b)(3)(C) (defining, for purposes of calculating subsidies, "adjusted monthly premium" as that "which would have been charged . . . for the plan if each individual . . . were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act"). The result of these two provisions is that insurers can increase premiums for tobacco use, but premium subsidies will not cover such increases.

²⁷⁶ See *supra* subsection II.B.2.

²⁷⁷ See PPACA § 1401(a), 26 U.S.C.A. § 36B(b)(3)(C).

²⁷⁸ \$27,075 is based on the 2010 federal poverty level guide. See 2010 HHS POVERTY GUIDELINES, *supra* note 166, at 45,629 (identifying \$10,830 as 100% of the poverty level for an individual). The numbers used in the example above are rounded for simplicity.

²⁷⁹ HCERA sec. 1001(a)(1), § 1401(a), 26 U.S.C.A. § 36B(b)(3)(A)(i).

this plan.²⁸⁰ Even though the insurer can charge her up to \$7500, her premium subsidy is calculated based on the excess of the standard \$5000 premium over her expected contribution of \$2180. She will receive a subsidy of \$2820. If, however, her policy costs \$7500, her actual contribution could be as high as \$4680 (over 17% of her income), as compared to \$2180 (8% of income) for a similarly situated nonsmoker. From a Brute Luck perspective, this additional contribution could be considered her “smoker’s tax” for taking on avoidable risks.

On the flip side, if this same smoker received a 30% discount on her premiums for participation in a wellness program for smoking cessation, her actual premium would be \$5250 (a 30% discount off of the \$7500 smoker’s premium).²⁸¹ In this case, her engagement in a program aimed at risk avoidance would lower her out-of-pocket exposure to \$2430 after the subsidy, still more than the nonsmoker’s \$2180 contribution but less than if she did nothing to improve her health. Plus, if she successfully quits smoking through the program, she will benefit from the nonsmoker premium in future years.

Table 1: Comparison of Subsidized Insurance Costs for Smokers and Nonsmokers

	Premium Charged	Subsidy Amount	Out-of-Pocket Costs (% of income)	“Smoker’s tax”
Nonsmoker	\$5000	\$2820	\$2180 (8.05%)	N/A
Smoker	\$7500	\$2820	\$4680 (17%)	\$2500
Smoker in Wellness Program	\$5250	\$2820	\$2430 (9%)	\$250

Thus, as intended, this Brute Luck policy provides rewards for those who avoid harms, but to the degree that someone knowingly assumes risk of harms, she is vulnerable to the costs of the risks she assumes. In the next Section, I will explore how this Brute Luck policy conflicts with both Health Promotion and Financial Security aims.

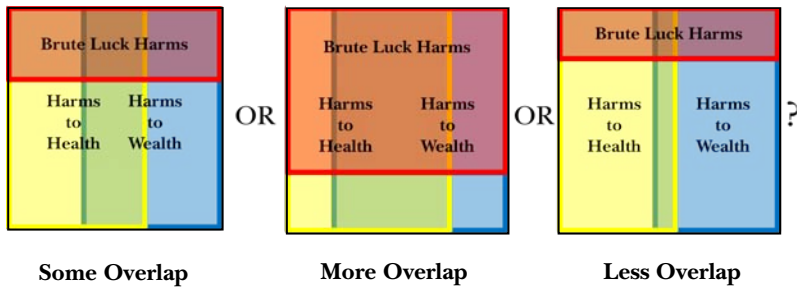
²⁸⁰ See PPACA sec. 1201, § 2701(a), 42 U.S.C.A. § 300gg (amending the Public Health Service Act provisions prohibiting discriminatory premium rates).

²⁸¹ See id., § 2705(j)(3)(A), 42 U.S.C.A. § 300gg-4(j)(3)(A) (providing for a maximum discount of thirty percent).

D. Conflicts and Policy Discordance

Is it possible to imagine a system that promotes health, in which people contribute to the extent that such contributions do not pose financial risk, and which insures primarily (or only) chance harms? The three notions clearly overlap to some degree, and there are policies, residing in the areas of full overlap, where the principles and goals of all three are harmonious.

Figure 2: The Uncertain Zones of Overlap



A policy requiring coverage of the costs of managing an unavoidable chronic disease, such as childhood diabetes for example, might be consistent with all three theories. Controlling the diabetes, which is likely the result of random bad luck, could greatly improve and prolong the child's life and will be very expensive, thus likely to create unmanageable financial risk for most families if not covered by insurance. The PPACA policy regarding preexisting conditions can likewise serve policy goals of all three conceptions of health insurance. To the extent prior exclusion of a preexisting condition from coverage prevented use of high-value, expensive care for an unavoidable disease, prohibiting such exclusions accords with goals of all three theories of health insurance.

It is possible to choose and craft policies to lie in these areas of overlap, but it is unrealistic to think that reconciliation of the three by way of operating completely in the space of overlap is possible or even desirable. As a threshold matter, even if possible, the space of overlap may not be the ideal space in which to create policy. Compromise policies may not optimize the goals of any of the three approaches if policies central to each theory fall outside of the area of overlap and only penumbral policies fall inside the zone of overlap.

In addition, whether because of normative conflict among the three conceptions or because of budgetary limitations, tensions or discordance among policies that further the goals of each conception are unavoidable. Two types of discordance are bound to arise. The first is what could be thought of as principled conflict, where the ideals of two of the theories are incompatible. Strong versions of each theory would demand that dollars should be spent *only* if compatible with the core goals of that theory. In this case, discordance arises any time a policy is not consistent with the goals of all three theories. The second is conflict in light of scarcity of funds. This weaker interpretation of each theory would say that each theory guides spending priorities but would not absolutely bar spending on other goals. This interpretation lessens discordance but would still lead to conflicts in application because each model would prioritize the use of limited budget dollars differently.

To illustrate, while the Health Promotion and Financial Security notions of insurance both justify covering many health services that respond to injuries or illness resulting from brute bad luck, they also both support coverage of losses that result from choice. Health Promotion theory justifies insurance coverage of smoking-cessation programs, regardless of whether the smoker chose to smoke in the first place, so long as such programs offer a high-value way to improve health. Likewise, a Financial Security model of insurance would cover lung cancer treatment to the extent that such treatment threatens financial solvency, even for someone whose own smoking was the primary cause of the lung cancer. The strong version of a Brute Luck approach would resist covering such harms in any circumstance, while a weaker version would deprioritize such coverage when funding is limited but would not bar coverage completely, particularly in a world of plenty.

Discordance is more frequent under the strong versions of the theories, but it will arise even under the weaker versions as PPACA is implemented. If budgets were flush, there would be less struggle over how to spend limited dollars. In the real world, however, there will be conflict, and regulators will be called on to resolve this conflict. The following subsections illustrate how the PPACA policies discussed in Part II create discordance among the ideals of the three conceptions of insurance. Part III then teases out ways regulators will have to address these explicit tensions as well as manage less obvious tensions that will also arise as the law is implemented.

1. Discordance Arising from Health Promotion Policies

The PPACA requirement that all insurance policies include first-dollar coverage of preventive care²⁸² is based on Health Promotion ideals and is largely inconsistent with the goals of the two other visions of insurance. From a Health Promotion perspective, concerns that people are not engaging in valuable preventive care—to their own potential health detriment—outweigh concerns of moral hazard. First-dollar coverage of preventive care (as well as the creation of federally mandated EHBs) increases the use of medical services to achieve better health outcomes. This increased use will almost certainly, at least in the short run, increase medical care spending.²⁸³

From a Brute Luck perspective, such a policy collectivizes costs that rational, responsible individuals should bear on their own. A strong version of Brute Luck insurance would not cover preventive care in most cases; a weaker version would make it lower-priority spending. Instead, Brute Luck insurance would be designed to create incentives for people to seek out prevention on their own to the extent they can reasonably do so.²⁸⁴ Toward such ends, not only would Brute Luck insurance plans not cover prevention, but they also would not cover the costs of downstream services an individual might need if she unreasonably failed to invest in preventive care. Excluding coverage of such downstream harms is intended to create an incentive for an insured to invest responsibly in preventive services and to stave off expensive, avoidable harms. For example, although harsh, health insurance might deny a woman dialysis if she behaved in a way that stressed her kidneys in the first place, leading to kidney failure.

A strong version of a Financial Security theory would not support insurance coverage of preventive care for those who could afford it unless the particular services covered were proven to be cost-saving;²⁸⁵ a weaker version would deprioritize such spending. Such first-dollar coverage uses insurance resources to buy out the base of people who

²⁸² PPACA sec. 1001, § 2713, 42 U.S.C.A. § 300gg-13.

²⁸³ As mentioned in note 80 *supra*, studies disagree on whether preventive care will result in significant cost savings, even if the care is high-value in terms of health outcomes per dollar spent. Studies suggest that buying out the base (or paying for preventive services that people are currently using) is likely to have a net cost. See RUSSELL, PREVENTION'S POTENTIAL, *supra* note 80, at 8.

²⁸⁴ It might still cover such care for people who cannot afford it for reasons outside of their reasonable control.

²⁸⁵ See *infra* Section III.A for a discussion of prevention and the low likelihood of cost savings.

would have obtained preventive care, even if they had to pay out of pocket.²⁸⁶ Including all costs of preventive care under the umbrella of insurance intentionally and paternalistically funds prevention through insurance even for those who could afford it and did pay for it before reform. Requiring insurance coverage of these services redistributes their costs broadly among all insureds, including the lower-income insureds, who could, in turn, be subject to higher premiums. Unless these increased costs are counterbalanced by additional premium subsidies, these Health Promotion policies threaten to increase financial insecurity for some insureds.

2. Discordance Arising from Financial Security Policies

Policies motivated by Financial Security goals could likewise create conflict. For example, the prohibition of annual and lifetime limits could, in practice, undermine Health Promotion and Brute Luck goals. The unfortunate truth is that spending over an annual limit will result in some spending with low health value.²⁸⁷ To the extent that such spending is for end-of-life care, incurable and terminal disease, or expensive interventions with a low probability of success, using resources to pay for such care is low priority under a Health Promotion model. Further, harms that lead to extremely high medical expenses may result from what are typically considered unavoidable causes (e.g., hemophilia or Alzheimer's disease) or from arguably avoidable causes (e.g., liver transplantation due to alcoholism, extensive harms from a reckless driving accident, or costs associated with a multiple-gestation pregnancy from infertility treatment). Although it is naïve to believe that prohibiting insurance policy limits greatly increases self-harming behavior by indemnifying the costs of resultant harm, it might decrease incentives at the margin for insured individuals to avoid certain extreme medical harms or expenses. At the very least, the policy authorizes significant medical spending on harms that have arguably lower health value and to which insureds may have contributed.

A second example, while less likely, is that if employers do in fact self-insure to avoid coverage of EHBs in light of the restrictions on

²⁸⁶ Jonathan Gruber describes this problem by analogizing policymaking to tuna fishing and advocates designing policies that use public funds to expand coverage in a way that catches the uninsured "tuna" without also catching the already-insured "dolphins" in the net of publicly financed care (i.e., avoiding overinclusiveness). Gruber, *supra* note 7, at 585-86.

²⁸⁷ See *supra* notes 68-72 and accompanying text (discussing flat-of-the-curve spending).

policy limits on such benefits, the Financial Security prohibition on policy limits could undermine coverage of “essential” Health Promotion services. For example, if HIV care is included as an EHB and employers deem it too expensive to cover unlimited HIV-care expenses, they could self-insure to create a benefits structure that does not cover HIV care at all.²⁸⁸ Such exclusions would threaten health and possibly also the financial security of those in need of HIV care.²⁸⁹

3. Discordance Arising from Brute Luck Policies

As alluded to above, the Brute Luck policy that does not allow for greater premium subsidies for smokers—even though they may be charged higher insurance premiums than similarly situated nonsmokers—is in tension with both Health Promotion and Financial Security goals. As discussed in Section II.C, premium subsidies are based on a standard rate, even though a tobacco user might in reality pay 1.5 times this rate²⁹⁰ and expose the hypothetical low-income smoker to premium costs that could cost upwards of 17% of her income, as compared to 8% if she were a nonsmoker.

Application of this policy undermines goals of both the Financial Security and Health Promotion models. The cost of premiums alone could cause financial strain for the low-income smoker. Furthermore, if the smoker exhausts her income on premiums, she might be unable to afford the out-of-pocket costs necessary to consume medical care services. Alternatively, if premiums at 17% of income are unaffordable and she opts for a less expensive plan, her coverage will be less comprehensive and will have higher cost-sharing obligations, again resulting in greater potential financial exposure and less ability to access medical care due to high cost-sharing. Finally, she might decide not to purchase health insurance at all, especially because her higher smoker’s premium would exempt her from the individual mandate to carry insurance on “affordability” grounds.²⁹¹ Thus, the Brute Luck exclusion of

²⁸⁸ This example is based on a legal challenge to an instance in which an employer dropped coverage for HIV care in response to an employee’s expensive claims for services. See *McGann v. H&H Music Co.*, 946 F.2d 401, 403, 408 (5th Cir. 1991) (holding that this change in coverage did not violate ERISA because it was not motivated by retaliation against the employee).

²⁸⁹ This policy could also be seen simply as ineloquent, creating unintended consequences rather than conflict.

²⁹⁰ See PPACA sec. 1201, § 2701(a)(1)(A)(iv), 42 U.S.C.A. § 300gg(a)(1)(A)(iv) (West Supp. 1A 2010).

²⁹¹ She would be exempted from the mandate under the affordability exemption that applies to those for whom coverage is over eight percent of income, assuming the

tobacco status in the calculation of subsidies could leave her vulnerable to health and financial risks of being uninsured.²⁹² These are examples of conflicts that arise from policies that clearly reflect values of one of the three different conceptions of insurance. Regulators will be called on to mediate these conflicts, as well as further conflicts that will become evident only as policies are implemented.

III. MANAGING CONCEPTUAL PLURALISM AND THE IMPLEMENTATION OF PPACA

This final Part anticipates various ways that these multiple—sometimes conflicting—conceptions of health insurance make implementation of the law complex. It is difficult to know exactly where the policy discordance, described in Section II.D, will be the most contentious. It is also impossible to predict the many ways in which these different notions of insurance will influence interpretations of policies that, while neutral on their face, will come to reflect a particular conception of insurance in practice.

What is evident is that regulators will have to balance these three conceptions of insurance often. Regulators have no roadmap for how to prioritize or optimize these pluralistic conceptions of insurance when interpreting the law; at times, they may not even be aware that in simply making decisions informed by their own preconceptions about what health insurance should do, they are making choices that prioritize one conception over the others.

It is also evident that these interpretations will have a dramatic influence on the final shape of reform. The legislation leaves many important resource-allocation decisions to regulation. And the regulatory process has been, and will continue to be, closely scrutinized and widely publicized as it plays out on a symbolic political battleground.²⁹³ The examples below illustrate that, over the coming years, state and federal regulators and implementers will frequently need to define which conception of insurance PPACA will advance. They will do so when they define policies that are written with a particular conception of insur-

cost of the least expensive plan is not so low as to bring her costs down to eight percent of income, after the subsidy. *See id.* § 1501, 26 U.S.C.A. § 5000A(e)(1)(A).

²⁹² Perhaps this vulnerability is the beginning of a success story for Brute Luck deterrence. If the smoker quits, her health presumably improves, her premiums decrease, and the three theories' goals dovetail nicely. However, to the extent not all insured individuals yield to such incentives, policy discordance remains.

²⁹³ *See* Lichtblau & Pear, *supra* note 28 (highlighting political and policy conflicts arising as regulators fill in the gaps of PPACA).

ance in mind, as in the case of EHBs below, as well as when interpreting policies that are neutral on their face but could be translated to favor a particular conception of insurance. They will also do so when evaluating the success of a PPACA policy to the extent that the yardstick used measures success in light of normative interests of a particular conception of insurance. Finally, they will do so when determining whether to allocate resources to a policy that furthers one conception of insurance. In all of these situations, a clearer understanding of how the law *could* be shaped to accommodate different conceptions of health insurance could enable regulators to make more thoughtful and intentional decisions about how it *should* be shaped.

A. Challenges of Interpretation

Ideas about what insurance should do will affect the interpretation of many provisions of the law. Even policies that appear crafted with a particular vision of insurance in mind could just as easily be interpreted through the lens of another vision. Consider the above example of developing and defining which services insurers must cover as EHBs. The *Washington Post* recently reported that an independent advisory board has begun “what is likely to be a long and emotional process” to define EHBs.²⁹⁴ As discussed in Section II.A, the text of PPACA implies an expectation that covering EHBs will yield health benefits in a broad-based way and urges the Secretary to define services with Health Promotion values in mind.²⁹⁵ Yet, as discussed in Section II.D, a broad interpretation of EHBs grounded in Health Promotion ideals can undermine goals of both of the other models of health insurance by driving up costs and covering services contrary to their core goals.

With recognition of such tensions, regulators could interpret EHBs to either ground this policy solidly in Health Promotion ideals or instead redirect it to some degree toward Financial Security or Brute Luck goals. Take the example of “[m]aternity and newborn care,” an EHB category.²⁹⁶ If interpreted through a Health Promotion lens, any service that cost-effectively promotes the health of a mother or newborn would be included. The Secretary could broadly define mandated coverage to include a full range of maternal and child health services and cause the distribution of the costs of such services

²⁹⁴ N.C. Aizenman, “Basic” Gets Tricky in the Health-Care Law, WASH. POST, Jan. 15, 2011, at A2.

²⁹⁵ See *supra* notes 132-34 and accompanying text.

²⁹⁶ PPACA § 1302(b)(1)(D), 42 U.S.C.A. § 18022(b)(1)(D) (West Supp. 1B 2010).

broadly among insureds. This means that even those mothers who could easily afford the costs of maternity care and who are pregnant by choice will have insurance compensate their maternity care.

In contrast, under a Financial Security approach, the Secretary of HHS would require mandatory coverage of only those services likely to result in unmanageable medical expenses, such as expensive interventions necessary due to complications. Routine costs of childbearing might be regarded as unlikely to cause people financial insecurity, particularly if they could borrow to finance such costs over a number of years, and thus might not be included as EHBs. Fewer maternity-related costs would thus be broadly distributed among insureds, and the costs that would be collectivized would be those most likely to cause financial insecurity for individuals if not collectivized.

If taking a Brute Luck perspective, the Secretary could choose to mandate coverage of only those costs that an insured could not have avoided, which, depending on how they are interpreted, might include very few of the costs for a noncoerced, routine pregnancy. Pregnancy is typically not the result of poor brute luck; for the fortunate, it is exactly the opposite. However, because demand for maternal care results from, in most cases, a conscious decision to engage in sexual intercourse, which logically might result in pregnancy, its related costs might not be covered under Brute Luck insurance.²⁹⁷ Although this final “tough love” interpretation places a significant burden on individuals and is questionable public policy for other reasons,²⁹⁸ it offers a valid way to interpret the maternity-care EHB. Because the meaning of this policy could have such dramatically different outcomes depending on its interpretation, it is not surprising that reports indicate that the early discussions regarding such decisions are highly charged. Although wrestling with the three conceptions of insurance explicitly will not necessarily make it any easier to draw regulatory lines, informed regulators will be more aware of the

²⁹⁷ Of course, there are a range of situations in which pregnancy or other health issues result from forced or coerced intercourse, or where reasonable efforts made to prevent the pregnancy were unsuccessful (e.g., failure of birth control). In such situations, pregnancy might be treated as a brute luck event.

²⁹⁸ From a deterrence standpoint, not covering childbirth might serve to discourage people from having more children than they can afford or require that people save for the costs of children they do have—a policy some might consider reasonable. However, this policy also discriminates against the poor and violates some egalitarian sensibilities. In addition, even if the pregnancy is a choice, failure to cover prenatal care might harm the infant, triggering a chain reaction of future brute luck medical harms.

implications of different definitions and the normative tradeoffs at stake in choosing a particular one.

B. *Challenges of Evaluation*

As when they are charged with interpreting a given policy, when regulators are asked to evaluate the success or effectiveness of a policy, they are inherently relying upon a particular conception of the goals of insurance to define success or effectiveness. Consider the implementation of the wellness programs discussed above in Section II.C. PPACA limits wellness-program discounts (for those wellness programs where the reward is “based on an individual’s satisfying a standard that is related to a health status factor”) to thirty percent of the cost of coverage,²⁹⁹ but it allows for these discounts to grow over time. It provides that “[t]he Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available . . . to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.”³⁰⁰ PPACA requires these three agencies, acting together, to determine when an increase is “appropriate” and thus when to allow wellness programs to become a more prominent feature of insurance plans.

But what determines the definition of appropriate? The answer will depend on what conception of insurance a regulator has in mind when making such a judgment. If appropriate is judged through a Brute Luck view of insurance, it would be sufficient that wellness programs are promoting efficient risk avoidance. From a Health Promotion perspective, an increase in the available discount might be reasonable if it will further improve health; yet, under a strong version of the theory, it would not be enough that people are lowering risks of harms (and thus improving their health) if the dollars for additional discounts would offer greater health value if spent in other ways instead. From a Financial Security perspective, these programs are most valuable when they result in health improvements where the dollars saved in future medical care costs outpace the discounts paid out. This result would occur if an individual is spared future unmanageable costs or if, at the system level, premium costs could be reduced across the board. However, as the above discussion of cost savings from prevention suggested, it is unlikely that either of these cost-

²⁹⁹ PPACA sec. 1201, § 2705(j) (3) (A), 42 U.S.C.A. § 300gg-4(j) (3) (A) (West Supp. 1A 2010).

³⁰⁰ *Id.*

savings benefits will be realized. Thus, from a Financial Security perspective, it would not be particularly valuable to spend additional dollars on discounts, even if the programs resulted in improved health.

Another, perhaps less obvious instance in which these three conceptions will inform the definition of success of a policy is the review of premium increases. PPACA directs the Secretary of HHS, in conjunction with the states, to develop a process for annual review of premium-rate increases to determine when such increases are “unreasonable.”³⁰¹ However, PPACA does not define unreasonable, nor does it provide any process for determining reasonableness. The proposed regulations are not much more concrete. They indicate that the Secretary will adopt a state’s standards for reasonableness, wherever a state has an effective rate-review program and communicates its findings in a manner directed by HHS.³⁰² This means that the determinations might vary state by state. To the degree a state’s review program is lacking, HHS will review increases above ten percent to determine if they are “excessive,” “unjustified,” or “unfairly discriminatory.”³⁰³

What is “unreasonable” depends in part on why rates are increasing. The proposed rule defines a rate increase as excessive if it “causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage.”³⁰⁴ This means that regulators will have to look at the benefits to see if they warrant concomitant rate increases. If regulators interpret what is unreasonable from a Health Promotion perspective, any increases that do not mirror growth in health-promoting coverage might be unreasonable. Under a Financial Security approach, the test of reason might be based upon how much the premiums increased in comparison to inflation or wage growth to gauge how much the premium growth could further eat into family disposable income. Under Brute Luck scrutiny, premium increases might be unreasonable if they result from greater coverage of avoidable harms (or from the increased costs of covering those avoidable harms already within policies). Other factors will of course inform reasonableness as well, including the sheer percentage of the increase and the rates prior to the increase. But a de-

³⁰¹ *Id.* sec. 1003, § 2794(a)(1), 42 U.S.C.A. § 300gg-94(a)(1); *see also* Rate Increase Disclosure and Review, 75 Fed. Reg. 81,004, 81,005 (Dec. 23, 2010) (describing section 1003).

³⁰² Rate Increase Disclosure and Review, *supra* note 301, at 81,007, 81,027 (to be codified at 45 C.F.R. pt. 154).

³⁰³ *Id.* at 81,026 (to be codified at 45 C.F.R. pt. 154).

³⁰⁴ *Id.* at 81,027 (to be codified at 45 C.F.R. pt. 154).

termination of whether the increase is valuable will in large part turn on what uses of premium dollars regulators determine are worthwhile.

C. Challenges of Prioritization

Finally, sometimes regulators will have to make decisions where they are not actively choosing a particular conception of insurance in defining or evaluating a policy, but rather where their decisions will (either intentionally or not) determine the expansion or contraction of resources for policies that favor a particular conception. An early example arose in defining regulatory specifications for the “medical loss ratio” requirement.³⁰⁵ PPACA requires that insurance plans spend eighty to eighty-five percent of premium dollars on “reimbursement for clinical services” or “for activities that improve health care quality.”³⁰⁶ The HHS Secretary, under advisement from the National Association of Insurance Commissioners (NAIC), was tasked with defining what activities “improve health care quality,” including those designed to “[i]ncrease the likelihood of desired health outcomes” in measureable ways.³⁰⁷

The interpretation of what is designed to promote desired health outcomes effectively validates and perpetuates investments by insurers in particular types of Health Promotion spending. In its letter advocating for a broad definition of what it means to improve health care quality, America’s Health Insurance Plans (AHIP), the lobby for private insurance companies, wrote that a too narrow or static definition was risky: “This would take us off the course of creating a 21st century health care system and create new barriers to investment in the many activities that health plans have implemented for the primary purpose of improving health care quality.”³⁰⁸ Although AHIP’s motivations may not have been as selfless as its words suggest, its statement reflects what is at stake with the regulation—the definition of how broadly

³⁰⁵ PPACA secs. 1001, 10101, § 2718(b)(1)(A), 42 U.S.C.A. § 300gg-18(b)(1)(A).

³⁰⁶ *Id.*

³⁰⁷ Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 74,864, 74,924 (Dec. 1, 2010) (to be codified at 45 C.F.R. pt. 158) [hereinafter *Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements*].

³⁰⁸ Letter from Jeffrey L. Gabardi, Senior Vice President, America’s Health Insurance Plans to Mr. Donald B. Moulds, Acting Assistant Sec’y for Planning and Evaluation, Office of the Sec’y, Dep’t of Health and Human Servs. 3 (May 14, 2010), available at [http://www.thecre.com/pdf/20100613_AHIP%20MLR%20letter%20\(5-14-10\)_FINAL.pdf](http://www.thecre.com/pdf/20100613_AHIP%20MLR%20letter%20(5-14-10)_FINAL.pdf).

regulators encourage investment in activities that offer potential to improve health.

The HHS Secretary issued an interim final rule in December 2010, adopting language proposed by the NAIC.³⁰⁹ This rule cast a wide net around activities that are considered potentially health promoting. Activities that improve health care quality were defined to include “care coordination, chronic disease management,” and activities “[i]dentifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.”³¹⁰ Several intensive services, such as “[p]ersonalized post-discharge reinforcement and counseling by an appropriate health care professional” and “[c]oaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition” are also included.³¹¹ The few limitations include that activities must “[b]e directed toward individual enrollees or incurred for the benefit of specified segments of enrollees.”³¹² In addition, wellness-program administrative costs are excluded,³¹³ as are activities “designed primarily to control or contain costs.”³¹⁴

What are the implications of this broad definition? First, it validates a Health Promotion vision of insurance. By including such activities that support Health Promotion values in the numerator of the medical loss ratio, the Secretary creates incentives for insurers to invest in a wide range of activities that may have potential to maintain or improve health. Second, in doing so, the Secretary *de facto* prioritizes the Health Promotion vision over others. The rule’s regulatory impact analysis recognizes that “increases in quality-improving activities or in consumption of medical care . . . have some benefit to enrollees but they also represent an additional cost to issuers and society.”³¹⁵ Thus, more dollars will be spent on those activities central to a Health Promotion conception of insurance (but not to the others, especially considering that wellness-program administrative costs are excluded from the numerator) in a way that is likely to increase insurance premiums. In

³⁰⁹ Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements, *supra* note 307.

³¹⁰ *Id.* at 74,924.

³¹¹ *Id.*

³¹² *Id.*

³¹³ *Id.*

³¹⁴ *Id.*

³¹⁵ *Id.* at 74,895.

effect, the medical-loss regulations increase the share of insurance dollars allocated to a Health Promotion conception of insurance.

These examples illustrate a small sample of the instances in which regulators have already begun to make decisions that support a particular understanding of what insurance should do and to what degree. Many more such cases will undoubtedly arise over the coming years. Understanding the deep, normative interests that these types of decisions implicate could help regulators to make such decisions in more informed and thoughtful ways, as well as to anticipate likely objections to their regulatory choices.

CONCLUSION: THE FUTURE OF CONCEPTUAL PLURALISM AND HEALTH INSURANCE

PPACA captured three distinct American conceptions of health insurance by simultaneously pursuing policies that reflect the values of each. Understanding these three conceptions of insurance and how they are reflected in PPACA's policies makes it clearer what is at stake in the implementation of health care reform. Each of these conceptions envisions that PPACA's expansion of insurance will solve a somewhat different problem by collectivizing risks. A Health Promotion vision of health insurance first and foremost anticipates that insurance reform will make Americans healthier, mitigating the risk that inefficient or unjustly inequitable access to medical care will compromise Americans' health. In contrast, a Financial Security vision expects insurance reform to address concerns with medical bankruptcies and health care costs rising out of pace with what Americans can afford; expanded health insurance should ensure financial security by prioritizing indemnification of costs that cause an insured real threat of financial insecurity. Finally, a Brute Luck approach expects insurance reform to address two problems: Americans' vulnerability to unavoidable health harms and, on the flip side, the failure of Americans to take reasonable responsibility for self-care where possible. To solve these problems, health insurance reform would ideally advance health justice and increase personal responsibility by prioritizing coverage for, and distributing the costs of, unavoidable, brute-luck harms. At the core of each theory are principles for rationing the use of insurance-premium dollars. Each deems certain types of harms more worthy of solidaristic treatment, as Americans more evenly share risks with others in their risk pool, and taxpayers at large share the costs of harms for those receiving subsidies for insurance. The case for reform is neither clear nor simple.

I had initially called this Article “The Theoretical Incoherence of PPACA.” But this title would have implied that conceptual pluralism is undesirable and that we should strive to achieve theoretical coherence, choosing only one among these ideas. It is not apparent, however, that conceptual pluralism should be eliminated.

It clearly creates challenges. It makes implementation more complex—requiring frequent mediation of conflicts and tradeoffs that arise from policies rooted deeply in distinct normative visions. The conceptual complexity of the law may also contribute to Americans’ apparent confusion with respect to reform. Americans are ambivalent about the law.³¹⁶ Although there are many reasons why people dislike or feel ambivalent about health reform, there is reason to believe that complexity is a contributing factor. It is apparent that Americans do not understand the reform.³¹⁷ President Obama has struggled to distill the benefits of the law into compelling sound bites.³¹⁸ And few people—even educated physicians and academics in the field—truly

³¹⁶ See Lydia Saad, *By Slim Margin, Americans Support Healthcare Bill’s Passage*, GALLUP (Mar. 23, 2010), <http://www.gallup.com/poll/126929/slim-margin-americans-support-healthcare-bill-passage.aspx> (finding forty-nine percent of Americans in support of the law following passage); see also *Kaiser Health Tracking Poll—September 2010*, HENRY J. KAISER FAM. FOUND. (Sept. 27, 2010), <http://www.kff.org/kaiserpolls/8104.cfm> (noting that “the public remains divided on the new law”); *Kaiser Health Tracking Poll—December 2010*, HENRY J. KAISER FAM. FOUND. (Dec. 14, 2010), <http://www.kff.org/kaiserpolls/8127.cfm> (showing that even by the end of 2010, “the latest tracking poll shows the public still divided in their views of the health reform law”).

³¹⁷ While polling numbers have fluctuated regarding the percent of Americans who support the reform, they have been consistently high on the number who do not understand it. See *Poll: Most Don’t Understand Health Care Changes*, CBSNEWS.COM (Sept. 22, 2010), <http://www.cbsnews.com/stories/2010/09/22/politics/main6890653.shtml> (“Six months after President Barack Obama signed landmark legislation that will extend health care coverage to millions of people, Americans still do not really know what the law does.”); see also Ricardo Alonso-Zaldivar & Trevor Tompson, *AP Poll: Health Care Law Making Us Muddle-Minded*, ABCNEWS, Sept. 22, 2010, <http://abcnews.go.com/Business/wireStory?id=11693092> (noting, for example, that “[m]any who wanted the health care system to be overhauled don’t realize that some provisions they cared about actually did make it in”).

³¹⁸ See Alonso-Zaldivar & Tompson, *supra* note 317 (“The uncertainty and confusion amount to a dismal verdict for the Obama administration’s campaign to win over public opinion.”); Sara Kliff & Carrie Budoff Brown, *Voters Not Budging on Health Care*, POLITICO (Jan. 19, 2011, 5:50 PM), <http://www.politico.com/news/stories/0111/47801.html> (“Despite the millions spent on advertising, countless town halls and a reinvigorated debate over the new health law, neither party has accomplished the key goal: swaying public opinion on health reform.”); see also Sarah Kliff, *Obama’s Health Care Hard Sell*, POLITICO (Aug. 10, 2010, 4:29 AM), <http://www.politico.com/news/stories/0810/40835.html> (discussing the administration’s challenge in “persuading seniors that the health care law is a good deal for them”).

understand what the law intends to do.³¹⁹ If the goal of the reform were singularly, for example, that no American would ever again suffer undue financial distress due to medical care expenses, Americans could understand this goal, judge it, and assess its success over time.

It is also likely that many people can identify some pieces of the pluralistic law that they support and others that they do not. For example, a Financial Security advocate might support the Medicaid expansion, subsidies, and prohibition of policy limits, and at the same time believe that the first-dollar coverage of preventive care is a waste. By deferring the opportunity to prioritize a particular normative conception of American health insurance, the reform may leave Americans confused and ambivalent about what insurance and insurance reform intend to (and perhaps should) accomplish.³²⁰

Yet conceptual clarity would also come at a cost. It may be that the most effective, stable, or popular policy results when all three conceptions are in balance. The conceptual pluralism underlying the policies of PPACA may accurately mirror the desires of a heterogeneous population. In this case, the ideal regulatory approach would be to order and prioritize these conceptions thoughtfully, but not necessarily to choose one and eliminate others. Tethering the reform too strongly to any one of the three theories would have made the reform more vulnerable to attack by those who would prioritize a neglected theory. If Americans are deeply divided and unmovable in their views of what insurance should accomplish, it is critical to maintain a pluralistic policy in order to appeal to a democratic majority. The real challenge of sustainable health insurance policy then would not be to root out the best approach, but rather to manage tensions among the three when they inevitably arise.

Alternatively, conceptual pluralism may serve as a kind of legislative experiment, setting up a structure where three different ideas are

³¹⁹ See John Leland, *Doctors Hear Many Questions About Health Law. Answers Are in Shorter Supply*, N.Y. TIMES, Apr. 19, 2010, at A12 (“After months of public wrangling and brinksmanship in Washington, the nation’s doctors now find themselves having to answer questions about a 2,400-page law that many do not understand themselves, and which they may have opposed.”).

³²⁰ Tom Baker writes about the ability of insurance to help shape notions of responsibility with respect to risk. See Tom Baker, *Risk, Insurance, and the Social Construction of Responsibility*, in *EMBRACING RISK*, *supra* note 74, at 33. As a corollary, if insurance implies several models of responsibility, it could fuel ambivalence regarding what we should expect insurance to do.

simultaneously road-tested for effectiveness and popularity.³²¹ One model might become more popular over time. Or one model might prove easier than the others to implement successfully. For example, as medical research advances, comparative effectiveness research could unlock the door to an unimaginably efficient, cost-effective system of insurance. If so, regulators could prioritize Health Promotion goals going forward and decide to turn to other tools, such as bankruptcy-law reform or expanded government welfare programs, to address Financial Security concerns that are neglected by health insurance. In contrast, it could play out, for example, that PPACA's Health Promotion goals prove too expensive or too difficult to implement through insurance and that the Financial Security goals are more straightforward, or perhaps more valued by Americans. In such a case, policy-makers could scale back insurance spending on, for example, preventive care to increase funding for the parts of the law that provide financial security, such as sliding-scale subsidies and the Medicaid expansion. Finally, if medical care costs continue to grow exponentially, greater future attention will likely focus on Brute Luck approaches that limit coverage to promote individual risk avoidance and attempt to contain costs. In such a case, while insurance might still seek to promote health and financial security, it might do so only with respect to medical care needs resulting from unavoidable harms.

For now, we cannot be sure which of these futures will emerge. Assuming the health reform survives constitutionality challenges (which one might interpret as resistance to the creation of more solidaristic health insurance markets in the first place), the defining features of American health insurance (whether pluralistic or not) will become clearer over time. The implementers of PPACA hold great power to shape future conceptions of insurance. The decisions regulators make either to prioritize one vision of health insurance or to hold multiple visions in balance will influence the future role of American health insurance and, in turn, shape what Americans expect from insurance in the future.

This Article has offered a framework to enable greater awareness of the multiple conceptions of insurance at play to provide a new lens through which to understand and evaluate this evolution.

³²¹ See generally Michael C. Dorf and Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267, 283 (1998) (describing democratic experimentalism as a form of government that "leave[s] room for experimental elaboration and revision to accommodate varied and changing circumstances").